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# INSANITY IN INDIA.

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## ITS SYMPTOMS AND DIAGNOSIS

With reference to the relation of Crime and Insanity.

BY

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LUNATIC ASYLUM, LAHORE.

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## PREFACE.

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THE object of this little work has been to give a brief but it is hoped fairly accurate account of the symptoms and diagnosis of the types of insanity that usually come under one's notice in this country. No attempt has been made to discuss the pathology or indeed to do anything, beyond attempting a clinical picture of the varieties met with.

Incidentally it has been also the endeavour of the writer to place on record the result of seven years' experience as Superintendent of this asylum (in which all the criminal as well as the ordinary insanes of the Punjab are collected) as well as that of four years before, during which he was in charge of various central jails in the same province, in the hope of assisting medical men in forming an opinion when called on, as they so often are, as experts, in regard to the sanity or insanity of the unfortunâte beings who have committed some legal offence while suffering from mental disease or of those others, who rarely, it is true, urge that plea to escape the consequences of their crime.

PUNJAB ASYLUM; }  
*Lahore, 1907.*

G. F. W. EWENS.

DEDICATED TO

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AND EPILEPTIC, LONDON ; IN EVER GRATEFUL  
MEMORY OF HIS TEACHING AND OF  
MANY YEARS OF KIND FRIENDSHIP  
AND ASSISTANCE TO THE  
AUTHOR.

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# INSANITY IN INDIA.

## CHAPTER I.

### INTRODUCTION.

INSANITY in India is, of course, essentially the same as insanity anywhere else in the world, though its evidences equally, of course, are modified by the environment, habits and customs of the people.

No one would necessarily regard a woman as insane in Europe, who appeared in public with her head uncovered, but no one with any experience in this country would have any doubt on the matter if he saw a native female here voluntarily doing so. On the other hand, were an Englishman in England to persist in acting and attiring himself as a faqir does in this country, it would be reasonable to suspect him of insanity, and similar examples of this character are endless. For some other reasons the types of mental disease seen in asylums here are very different to those usually seen in Europe. Here the law is so worded that practically only those insanes too dangerous and troublesome to be left in their relative's charge, those found helpless wandering about, or who are unprotected, are placed in an asylum, these also are few in number; the people have an intense objection to allowing sick relatives to leave their charge, and it thus results (1) that the number under treatment is excessively small (in the Punjab, only some 600 out of a population of over 22 millions,) and (2) that these are all of an excessively dangerous and troublesome class. If all the dangerous, noisy, turbulent, destructive men from every asylum in the United Kingdom and all those in Broadmoor were collected together, some faint idea might be realised of the class of patients one has to deal with here. There are quiet ordinary insanes, of course, but such do not come to an asylum; they remain in their own villages. Then everyone will allow that an insane tends to show a reversion, sometimes an exaggeration of his natural self. The natural self of a Pathan, an Afghan, or any of the Frontier tribes, or even a

Punjabi is not of a docile, amenable description—quite the contrary, and so it happens that specially in this asylum full of such men freed by their disease from the restraints that ordinarily influenced them—noise and turbulence, violence, aggressiveness and reckless actions are predominant features. Suicide is very rare, and murder or attempts at it not uncommon.

The most striking fact, however, is that certainly the number of insanes in the population is very small, and compares in this respect in a most wonderful way with Western nations.\* The greater simplicity of life here the effect of the climate, tradition and training in rendering the people fatalistic and patient, their conservatism and dislike to “hustle” the very fact of so many of their insanes being untreated and probably showing then a high mortality, and so checking the transmission of the tendency to the disease may possibly account for the difference which, whatever be the cause, undoubtedly exists. On the other hand some causes of insanity, notably that from the use of Indian hemp unknown at home, is here common and *vice versa*. General paralysis of the insane is never met with among natives of the country.

Another very striking peculiarity of insanity here is the small number of females affected; they have never been more than  $\frac{1}{300}$  of the male, though this of course refers to those seen. It is scarcely necessary to add that any objections the people may have to allowing a male relative to enter an asylum is increased a thousand-fold where these women are concerned; disease affecting them is studiously concealed and probably those we know of form only a small proportion of the number actually afflicted, but of this it is impossible to speak correctly. In most cases those we have here have been found wandering and unprotected at large, having as a result of their illness slipped away in an unguarded moment.

The types of insanity under treatment are best shown by the table I append (which also shows the number under treatment here) of them for last year, the relative proportions of those not varying much annually. It will be noticed that mania (and this is usually acute) far outnumbers the others. Simple quiet suicidal melancholia, such as one sees so many of at home, are, practically unknown here. Such people are in a convenient condition to be retained at home and allowed to follow their own wishes, or if they

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\* The population of the Punjab at the last census was 20,330,339, and the number of insanes was only estimated at 7,774 or 0·037 per cent.

show any troublesome tendencies to be, as is the custom, tied to the leg of a bedstead, bled at intervals, taken to various *pirs* or *faqirs* to be treated by charms and by various other similar methods far more esteemed among the people than any treatment however sedulous and sympathetic that they receive in a Government asylum.

Just as certain types necessarily predominate, so do certain symptoms in the asylum. It can scarcely be wondered at that people who habitually use any open ground in the vicinity of their village as a latrine, who regularly plaster with their own hands liquid cowdung on their floors and have various other similar habits, should, when insane, be what to us is disgustingly filthy with their excreta, and this is what the vast majority of these acutely insane invariably are.

Equally it is not surprising that in a land where a coolie will work naked, except for a minute shred of clothing over his groins, and where for six months in the year the climate is such as to make a European even rather envy him, that an insane should be almost invariably naked, and that many should insist on being so.

For the same reason in a country where small children are heard proficient in most vile abuse or what seems so to us it cannot be wondered at, that the language and conversations of an insane should be largely made up of the same.

In asylums here too the care of the insanes is greatly hampered by the total absence of anything corresponding to the well-trained conscientious, painstaking nursing staff one can obtain at home. The work here is rightly regarded by the ordinary native as dirty, it is for what is required of him badly paid, and only a very low class socially and intellectually will engage for the purpose. The eternal questions of caste and religion still further complicate the matter; a high caste man will not wash a patient; only a sweeper will do so—such cannot be allowed to touch the food. Hindoos object to being attended by Mahomedans and *vice versa*. Europeans are unattainable, and even when the patient himself might be too insane to have views on the subject, the friends and relations have very strong opinions, and these difficulties are endless and affect every little detail essential to their care and provision, and thus it happens that not only do the types, the symptoms differ, but their method of care and supervision differs from that in Europe. Still the rate of mortality is low and that of recovery is high, and both compare favourably with the same elsewhere, and if, as is the case, the standard of comfort of food and clothing, the attention and

kindness the patients receive be immeasurably superior (as I have convinced myself by personal observation) to that which they obtain in their own homes, and, indeed, anything they have ever been previously accustomed to then the question as to whether the standard is above or below that usual in asylums in Europe or America is as every thoughtful individual will allow of little practical importance.

Among natives of this country insanity is looked upon from a different point of view to that of our own. With the majority of Hindoos asceticism or the relinquishment of family ties and responsibilities and of all occupation, rank highest in their estimation as a proof of religion. The mass of the people know nothing of pure morality apart from such observances to which the climate and habits of all give endless facilities, and therefore, as is natural, they do not look on disordered men or nakedness or wandering in that condition throughout the country as anything unusual. The people as a whole, are slaves to custom and habit, and so it happens :—

That they are easily imposed on by fanatical shrewd insane and half-witted people who take on these practises. They have a great respect for faqirs, a class of men who wander about the country or who at certain "seats" live in the open upon alms with little clothing, beyond their matted hair and the ashes and dirt upon their body. Their habits are well known. When a man falls into trouble or becomes destitute (and most who recover from insanity) such promptly go out into the world as faqirs, the vast majority of whom are habitual consumers of hemp in the form of *charas*, as indeed are nearly all religious mendicants, and I have no hesitation in saying become or are more or less insane. Their extravagant actions and habits being condoned on account of their supposed religious occupation.

With all natives an ordinary melancholic or indeed any insane without derangement of speech is not regarded by them as being insane at all whatever delusion he may own to. And a large number of persons on the other hand, who are even to them obviously insane are regarded as having been bewitched—put under the influence of a spell, etc. The writer was once called on to see a great personage whom he found lying (as he had been for six months) in a state of melancholic stupor. He had some 18 months before in order to procure space for the enlargement of his palace pulled down two small temples, and it was universally believed that his insanity was nothing but a trance into which he

*Admissions and discharges of Patients into Punjab Asylum  
from 1st January 1900 to 31st December 1906.*

			Discharged cured.		TRANSFERRED.				Deaths.		Percentage of deaths to average strength.		
					Improv- ed.		Not improv- ed.						
			M.	F.	M.	F.	M.	F.	M.	F.			
Remaining on 1st Jan. 1900			356	101									
Admitted during 1900			131	20	37	1	25	3	4	2	38	12	10.59
Do. do. 1901			111	17	36	3	21	2	1	0	43	13	11.40
Do. do. 1902			125	23	36	8	20	6	2	0	30		7.94
Do. do. 1903			125	36	43	6	21	1	2	3	28	12	7.64
Do. do. 1904			137	31	50	15	12	0	1	1	27	13	7.22
Do. do. 1905			151	33	59	11	21	1	2	1	46	10	9.38
Do. do. 1906			131	43	55	13	32	3	1	1	40	17	9.43
Total.	...		1,267	302	316	57	152	16	..	..	252	86	10.6
					25%	4.3%							

*Examples of Type of Insanity (Government Classifications)  
during 1906.*

	Idiocy.			Mania Acute or Chronic.			Melancholia Acute or Chronic.			Dementia already acquired.			Mental Stupor.			Delusional Insanity.		
	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.
Total treated	28	16	44	347	62	409	130	40	170	15	10	25	2	1	3	23	2	25
<i>Epileptic during same year.</i>																		
Total treated.	..	..	..	48	9	57	5	6	11	4	..	4	Total—M. 57. F. 15=72.					

These statistics of recoveries, deaths, etc., are practically vitiated by the fact that in the asylum, criminal insanes are also detained there forming a very large proportion, 1 in 6, and as all have to pass a very long period of probation here when sane, before any question of their discharge can be considered, and those who have committed homicide are rarely even then permitted, to leave, it follows that the numbers of them recovered are as a matter of fact, very much higher than those given which are practically only of the non-criminal insanes.



had been cast in revenge by the gods of these buildings. Even if they allow that the insanity exists, they always assign a similar reason for it, that the man had insulted a priest or a faqir, defiled a temple, etc., and, of course, all these beliefs make them still more convinced that the only proper treatment is of an analogous nature. A still more renowned temple must be visited to avert the spell or a still more powerful yogi or faqir must be appealed to and propitiated. When in despair they do resort to treatment, this is always restricted to mechanical restraint (chaining to a tree or a bedstead), bleeding or applying the actual cautery to the vertex of the skull or the nape of the neck, and many patients arrive here with the scars resulting from this operation. With the Mahomedans practically the same beliefs hold. Given an adhesion to religious practices the most extravagantly insane acts are condoned as those of a God-inspired man. On the frontier practically all lunatics are looked upon as being of this nature and much the same idea is held throughout India. A poor feeble old woman begged us once to give back her son a helpless dement filthy and unable to speak three coherent words, as she wished to put him in the gate of the village to be consulted as an oracle, so that as she naively put it she might be supported in the offering made to him.

Nor are these opinions as might be imagined confined to the poor and illiterate. In the appendix case No.— is given that of Mahomed Bux, who though so insane as to be almost incomprehensibly incoherent and so deficient in control that he once committed murder, was regarded by the whole of Lahore, by Mahomedans and Hindoos alike, as a holy and powerful man who by constant "meditation" had acquired such power that he controlled a "Jin" and could, thus if so inclined, grant his applicants any favour—he was visited daily not only by the poor, but also by rich merchants, men of good position, and even by graduates and native medical men trained by ourselves—men who could for examination purposes discourse learnedly on the causes and symptoms of this very disease, but whose sentiments, superstitions and influences of their environment were more powerful than all their learning by which they expected to live for the rest of their lives in Government employ. It may be added as evidence of popular feeling on these matters that one and all thought nothing of the murder condoned it on the grounds that "his holy thoughts were interrupted by the boy," whom he got

up and suddenly stabbed to death, and also that after his death a tomb was erected to his memory, to which there is to this day twice yearly a large pilgrimage. Though they think mad people inspired curiously enough. Mahomedans also believe in the influence of spells—one patient here was believed to have been made insane in this manner because he had removed the cloth from a Mahomedan Saint's tomb, and another to have been so punished by a Murshid he had insulted.

They too also believe in potions, charms and many other curious causes for mental disease. Insane from having been fed on owls' flesh, from having insulted a Mullah or as a result of studying divination are with many other similar statements often met with. On the other hand, all classes recognise the influence of Indian hemp in the production of what is to them "Nasha," more or less violent, though no instance of their ever attributing the same to opium has ever come under my notice.

It can easily be understood that all these beliefs tend to increase the objection they have to allowing a relative to enter an asylum and practically it is only when by reason of their malady they are so dangerous, troublesome and filthy, that it is impossible to keep them that they are ever brought here for treatment.

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## CHAPTER II.

### INSANITY IN GENERAL.

Insanity is a disease of the brain causing an alteration or impediment of the mind, and by so doing altering a person's conduct, speech, manner and habits from those of sane people or of himself prior to his illness. Though certain gross lesions of the brain, such as tumor, abscess, hæmorrhage, softening and head injury are found to be accompanied by an alteration most usually a weakening of the intellect, it must be owned that up to the present careful examination of the brains of most insanes after death has

discovered nothing certain to which insanity can be attributed. Undoubtedly this is due to our defective powers of observation, and in all probability it is only a question of time before such will be discovered. In the meanwhile it may be asked why we state so dogmatically that insanity is due to brain disease. Well an insane is one who has his mind diseased, and we know that the "seat" of the mind is in the brain for the following reasons:—

Gross lesions or diseases of the brain may cause unconsciousness—or insanity.

Insanity follows sometimes on brain injury.

Intellectual faculties purely may be only impaired for the same reason.

The intellectual capacity is in ratio with that of brain development.

Mental excitement, strain or fatigue induce a sensation usually localised in the head.

The brain is the central connecting point for the whole nervous systems and peripheral stimulation must be transmitted to the brain before sensation can occur, *i.e.*, if the connection is severed none results.

Mental activity is accompanied by an increase of temperature in the brain and by an increased excretion of waste products known to be elements of Nerve Cells, phosphorised constituents, etc.

Any interruption to the blood supply to the brain by means of the great arteries is followed by disturbance of consciousness.

The facts of comparative anatomy—that development of the brain and the degree of intelligence vary in direct ratio.

It is comparatively easy to recognise that a person is insane, but it is very difficult to give an accurate definition sufficiently comprehensive to include all its varieties, in the same way that it is easy to recognise anger but hard to describe it. One is often asked to do so especially in courts of law, but the wise man will always avoid doing so when possible. Many definitions have, however, been given and perhaps the least objectionable is that of Bucknell who describes it as a prolonged departure without perceptible cause from the state of feeling and mode of thinking common among sane people; due to disease of the brain affecting the integrity of the mind, this not being the mere symptoms or result of fever or passion, that is to say not being the passing symptoms of some disease or the temporary result of intoxicant—though strictly speaking the line cannot be drawn between these latter conditions,

*i.e.*, the delirium of fever and the conditions of acute drunkenness is each a very temporary insanity. Still for practical purposes we do draw a line at delirium and intoxication and essentially insanity is a loss of control of self.

Legally you will find it extremely difficult to induce anybody to accept your statement, that a person is insane unless you can prove the existence in them of a delusion, an insane idea—that a person should believe something which obviously is not and cannot be, more especially if he acts on it. For it must always be remembered that it does not necessarily follow that because a person is the subject of a fixed delusion that he should be sequestered in an asylum, some of these being absolutely harmless. The man who believes himself to be the King of the Punjab or the son of an English Peer as long as he contents himself with a complacent self-contemplation of his own greatness is quite as well at liberty, but it is a different thing when he begins to enforce his rights and to annoy everybody in his efforts to obtain them.

It can easily be understood that there is every gradation between the most marked cases in an asylum and an individual outside, who merely has a high belief in his own capacity and is practically only a vain foolish man held at his true estimate by all except himself. Insanity must always be regarded in its influence on conduct and on life and as to whether it really arises from a disordered brain, for there are many instances of absurd belief and even of hallucinations in people whom by no possibility can we call insane. Also a difference of race and training must be considered, an ignorant low class native who fixes a silver ring around each big toe and a ligature round his left upper arm in the belief of the medical efficacy of these is not necessarily a lunatic far from it, but a very strong belief of the mental unsoundness of a cultured European, who formerly had a strong prejudice against any such superstition might reasonably be entertained if one saw him commence acting in like manner. Hallucinations, or rather illusions of a very definite character may be met with in all sane men or in those temporarily in weak health and exhausted. An excess of alcohol will notoriously cause us to see two moons, will make the pavement rise up and hit us on the face; we may think that the egg, the juggler so dexterously produces has really appeared to come from our friend's eyebrow, or that the stick, half of which is in water is bent, and that we feel the toes or fingers of a limb long since removed by amputation, but these momentary beliefs we correct by our

judgment and reasoning and the evidence of our senses, and it is exactly this that the insane is unable to do, for him, the moon is double, the ground does rise, etc., the egg does come from the eyebrow, and the stick is bent and no reasoning or evidence will convince him of the contrary. Should he content himself with the belief and his assurance of the stupidity of the rest of the world who think in opposition—it is a small matter, but when he commences to modify his conduct in relation to this and to enforce his belief on others, then the question of removing him to an asylum is necessary. Therefore, if a definition of insanity must be given perhaps the best is that of Maudsley, who describes it as being such derangement, “of the leading functions of thought, feeling and will together or separately as disables the person from thinking the thoughts, feeling the feelings and doing the duties of the social body in, for, and by which he lives.”

Insanity, though it is a disease of the brain, is not necessarily or obviously accompanied by the physical symptoms of disease that we usually associate with such an affection. The patient is not paralysed, he has control over his sphincters, has no pain, headache or fever the change produced is a mental one, and being so is shown in his conduct and that as above said is the all-important point, for while it cannot be too surely remembered that insanity is the most dreadful disease man is subject to, dreadful in that it lowers him to the level of an animal, cuts him off from all sympathy and fellow-feeling with every other even indeed with his fellow-sufferers, in particular it is the only disease for which a person may be deprived of his liberty and secluded in an institution and prevented from acting freely, so that it is with regard to the latter point that legally the question of conduct is so important, and especially in this country where the law is so worded that practically only these patients dangerous and troublesome can be placed in an asylum.

Apart from the social and legal aspects it must be also remembered that only some 20 per cent. of those under treatment recover and of these many do so only to fall victims again perhaps 59 per cent. relapse; that it has a very heavy mortality at least 10 per cent., and that it has the dreadful property of its susceptibility, being usually handed down to one's descendants. Though it is difficult to prove this in India, it is believed elsewhere that some 70 per cent. show an hereditary tendency,\* insanity being found in the ancestors of that member. Not that

insanity itself is the only disease predisposing to its own production—it is one of the nervous degenerative stock, that is to say, that Hysteria, Epilepsy, Asthma, Migraine, Chorea, "Apoplexy" and Diabetes, Nervous disease in almost any form as well as alcoholism in the progenitors predispose to insanity in the offspring. Perhaps the most fatal of all combinations being that of a tubercular diathesis in the one side and a predisposition to nervous disease on the other. Children of such a union are extremely likely to become insane.

Whatever difficulty there may be in describing insanity there is none in recognising it, and it will be noticed that broadly speaking most insanes, in addition to the symptoms special to each variety of their disease, all present certain common characteristics.

Every variety of the malady exhibits as its essential feature loss of self-control, they are always solitary, never gregarious; the patients are in the real sense of the word peculiar; they think, dress and act peculiarly, and are always essentially egotistic, only thinking of themselves; they have lost all the higher refinements of manner and bearing, they are devoid of all respect; a very striking character in a nation of such servile habits as this that cannot fail to impress anyone with a knowledge of the country when visiting an Indian asylum. They have no regard for persons or consideration for others, and they are most unreasonable; the majority seem to have a fixed idea in the infallibility of their own opinions, and in any case it is impossible to reason with a lunatic just as it is impossible to appeal to his better feelings, to his politeness or sense of consideration for the convenience or for the feelings of any one beside himself against his own wayward impulses and emotions which are the sole directors of his actions instead of these following from a just reasoning of his possible acts, their consequences, and his environment as in a sane person. Then, too, they are almost always changed in their natural affections, usually disliking those with whom they have been most in contact and for whom they had previously the greatest affections—a wife when insane at once commences to detest her husband, a son, his parents, etc. They are one and all absolutely devoid of what is usually described as self-consciousness, and also one and all are absolutely unable to follow their usual occupation or livelihood, in short a person who is insane cannot look after himself or his affairs—is obnoxious to himself and others and to society in general, and is quite unable to "adjust himself" to his "environment."

## CHAPTER III.

## DIAGNOSIS OF INSANITY AND ITS SYMPTOMATOLOGY.

We speak of a person as being an idiot roughly as one who from his earliest years has been devoid of the usual "sense" of an ordinary person. Such must be separately considered. Apart from these the most striking symptoms of an insane is that when he becomes so he is changed from what he was before. The change may be of sudden onset or so gradual in its occurrence that the period of transition was not remarked—but even then when fully developed those who know the patient will tell you that such a one is different in his habits, his thoughts, manner, bearing, attitude, he no longer acts as he did before, he may dress differently or pay no attention to it, etc., and his physiognomy, features, expressions and speech are altered. Not only is he different from his own previous self, but he is different from the rest of the sane world; he looks on things in a different light, reasons, if he reasons at all, from unfounded premises or improperly, acts in an unusual manner—is egotistic; no insane is ever altruistic, he is not bound by the usual conventionalities of behaviour, is solitary, never gregarious, two or more insanes never combine, a very important and consoling fact when as here a large number of most dangerous men are crowded together—he is a stranger in a strange land, with his own views on everything which are usually different from what his own formerly were and what everybody else's are of his own race, country, station and age at the present time. Not only that, but he is incapable of following his own employment or occupation, he is not able to do so, and is not willing as a rule to try. Still it will at once occur to every one that in all persons afflicted with any ordinary "bodily" (so-called) disease this is so—the sufferer from pneumonia is changed and unable to follow his employment. This is true, but then the insane to all superficial observation is not ill-bodily, he has no rise of temperature and he is not "bodily" incapacitated, he has not necessarily any cough, pain, diarrhoea or other physical symptoms. It is his will—the inclination, the mental ability to do so that is lacking—in short, insanity shows itself by its mental symptoms and these only, and this is most important in regard to the mistake that is so frequently made of sending a person suffering from the initial delirium of some acute disease to an asylum as insane in the ordinary sense of the word. In some few people of neurotic type and history the delirious symptoms may be so much in evidence

and those special to the malady so masked that such people have been certified as insane, who are merely in the initial stage of typhoid, scarlet fever, measles, small-pox and pneumonia—a case of plague even has been admitted to an asylum. The majority of such cases are evidences of gross carelessness. In all instances of supposed insanity of acute onset the temperature ought to be taken—there is only one variety of mental disease acute delirious mania, in which the temperature is raised, and whenever this is found to be so, a most careful examination ought to be made for the existence of rashes or for any disease of the lungs, the other organs of the body and the glands. A person truly insane will present nothing practically to account for his symptoms—he is quite able to walk, eat and attend to himself—he is not physically incapacitated—he is so mentally. Apart from the question of temperature, a thorough examination ought always to be made of the condition of all the body, organs when investigating a case of insanity so as to exclude any disease and to be able to estimate justly the patient's account of himself, indeed it will be found of advantage to question him first as to the state of his "health," for a patient is accustomed to these inquiries will more readily speak and is less liable to become suspicious and to withhold information.

The diseased mind shows itself in different symptoms in each variety of insanity which will be all separately considered, but there are certain general mental symptoms common to many varieties which first need description and definition.

(i) An illusion—this is an erroneous interpretation of an ordinary sense impression.

(ii) An hallucination—a false perception of the senses (without any external stimulus to cause it).

(iii) A delusion—this is an insane belief one contrary to all experience and knowledge.

If a person sees a horse and believes he sees a camel—this is an illusion.

If he declares that he sees a camel when there is nothing there, or hears a voice behind him when there is really absolute silence, or feels a blow when no one has touched him, that is an hallucination.

If he believes that he is God, that he can fly, that he died five years ago, etc., that is a delusion. But as before said anyone may have an illusion or even hallucination when sane, but if it is pointed out to him that he is mistaken or it is proved so to him by



the evidence of the senses he accepts that and is satisfied. But an insane man will continue to believe in the illusion or hallucination even when adequate proof is afforded him of his error. He cannot be reasoned with and what is more important will act upon his belief. The same thing applies to delusions. A sane person may have a very unfounded belief in his own power and abilities or that some one is persecuting him, etc., etc., he may be under a delusion, but he will believe the evidence of experience and of his own senses when these prove to him that the opinion is erroneous. Not so the insane—who, if he believes himself capable of flying will not only continue in his idea, but will perhaps jump out of window to prove his ability, breaking his neck in so doing. No reasoning, no evidence can influence him as he is incapable of reasoning justly or of comparing any evidence given him. It must be always remembered that not all insanity is accompanied with delusion; some of the most dangerous varieties, epileptics, homicidal and impulsive insanes never have any.

Just as a delusion may be of any matter or fact, an hallucination may be of any of the senses, that is to say, that a person may see sights, hear words, taste articles, smell odours and feel stimuli none of which have any existence.

The loss of will-power, of self-control, is perhaps the most fundamental symptom of all form of insanity, an insane has no self-control, he does just what he pleases and also *en passant*, it may be added he will generally do nothing that he is asked, it is this which makes them dangerous and obnoxious. The majority are also defective in judgment power of comparison and of weighing facts and appreciating the relations of their environment, but even when their "faculties" are only slightly affected, the patient is unable to control himself. He acts on the slightest stimulus without reflection, also he is easily made irritable or equally easily exalted conditions in which too the disturbed or rather unregulated uncontrolled conditions of the emotions are also evident. He cannot act as his training, and habits have always led him to do previously in accordance with ordinary conventionalities and customs or in those rarer forms of insanity, though aware of what he ought to do, he is unable to control himself sufficiently. The power of attention is almost always defective, he is either self absorbed in some delusion or wave of emotion, feeling or thought—or else it is very easily divertible, attracted by any and every passing stimulus, so that it is not possible to retain it.

The memory is affected in many, less, so in the acute and active forms, to this though there are exceptions, than in the later stages when general weakness of mind has set in. The total consciousness itself may be clouded especially in the acute and rapid cases when the patient may not recognise those about him and has no idea of his location. Taken as a whole it is the latest formed characteristics of mind which are the earliest and the most deeply affected with the successive deeper and deeper involvement of mind and brain functions so more and more of the fundamental attributes of mind and mind's actions become disturbed and weakened.

In this way politeness, regard to convention and morality, regard for others are the first to go; the subject consciousness rises while the object consciousness falls as Bevan Lewis points out; the patient is impolite, rude, inconsiderate, loses all his "finer" and his "moral" qualities, is egotistic, boorish even, criminal—then his power of controlling thoughts, acts and speech is still more deeply affected; he becomes noisy, incoherent, filthy and naked until gradually with advancing dementia he sinks back as it were to the mental level of the little child from which his gradual evolution into a man had previously raised him. Certain insanes show their defective will-power in a tendency to various impulsive acts; they have been admirably classified by Clouston into General impulsiveness. Epileptiform *i.e.*, attended with no recollection of them. Sexual, morbid appetites for filth, a very common one in this country. Homicidal, suicidal, impulses to drink, to steal and to fire and alternating conditions.

"Imperative ideas" differ a little, in that there is some idea or phrase occupying monopolizing, all their attention and from which they cannot rid themselves. An obsession is practically an ever-present idea or desire to perform some act of a foolish nature. These various characteristics are more fully examined later: Just as the insane usually develops different habits from those usual to him before and to those among whom he lives so from his defective reasoning power, want of judgment and loss of control these are liable to be acts of an obnoxious, dangerous and criminal nature; indeed it may be roundly asserted that every lunatic is a potential criminal and must be regarded as such. Quite apart from this for the same reasons, his loss of the effects training and of will-power, an insane seems to revert to his natural self—his true nature comes to the surface, and this explains the dangerous habits of some of the insane frontier

tribes seen here—but with all, this is really the same and only varies with the individual. The naturally rough boisterous man who has been taught by training and education to control himself, if he becomes insane, loses this surface veneer; his mental disease is greatly characterised by horseplay, roughness and violence, and so with every race and sex. Apart from this, however, all chronic insanes have usually some curious habits often of a nature that renders them if not obnoxious at least troublesome, just as so many of them will dress themselves in some fantastic manner or ornament themselves with rubbish and rags or go naked; others will have some annoying habit or will persist in acting in an unnatural, filthy or indecent manner. Most probably on account of the loss of control over the emotions nearly always seen, the physiognomy of the insane is usually peculiar. The face often expresses some persistent emotions, exaltation, pride, gloomy rage and depression; always, it differs widely from a person suffering from any “bodily disease.” Just as characteristic is the total loss of expression seen when Dementia has fully set in.

The surroundings of a lunatic also are often characteristic, his apartment or house is unattended to, is filthy, or if well kept is arranged in some fantastic manner or often like his dress ornamented with symbolic drawings, tracery and letters, a fancy very common among such people, or some delusion may lead to the patient surrounding himself with curious objects. The dress though it may be clean and natural is quite as often neglected, disordered and filthy, or else adorned fantastically and absurdly or of an absurd description, or as so often happens in this country, the patient may throw off all clothing and go naked. Joined to all the peculiarities of conduct and appearances is, the disorder of the normal impulses to eat and to sleep most evident in acute cases when appetite is usually nil and sleep impossible. These two symptoms should always be enquired into.

## CHAPTER IV.

### SIMULATED INSANITY.

Insanity is sometimes feigned by prisoners with the object of averting punishment and more rarely for other reasons by ordinary people. I have seen it feigned to obtain retirement on pension.

(It is not a common act among native of this country). On the other hand people are sometimes suspected of malingering when they are really insane, and it is for this reason very necessary that a medical man should be able to form a correct opinion on the subject. Apart from this being possible by the fact of whether the symptoms correspond to those of a particular variety of insanity, there are a few commonsense indications of great importance in assisting one to detect malingering. In the first place there is usually a motive.

Secondly, it is obvious that a criminal, such as these people usually are, who wishes to feign insanity has to pretend to be suddenly affected. True mental disease, except in some rare cases usually begins slowly and with marked prodromata, then feigned insanity commences only after the prisoner has been accused of the crime, and a careful history of his bearing and manner for the period immediately previous will show this to have been absolutely normal. This question of the onset is of great importance, most true attacks of insanity commencing with a change of manner, loss of appetite, sleeplessness and general malaise, lasting for certainly some days. Then the family history should be inquired into to discover whether there has been any insanity, epilepsy or neurosis, likely to leave any tendency for the man to be so affected, above all, whether he has before ever suffered from insanity. Then as to the actual symptoms offered by the individual feigning to be a lunatic. (It is usually acute mania that is simulated.)

Does he sleep, nearly all persons acutely insane are unable to do so. Whereas a person feigning the disease becomes exhausted and falls asleep from sheer weariness. Does he like most lunatics refuse his food. Does he look ill, and has he lost flesh as do all cases of acute insanity of rapid onset. Is his speech really as rapid and incoherent as that of such a patient should be. Apart from these points the malingerer usually present some abnormal symptoms. He is always at his worst when visited, whereas the true lunatic is frequently quiet for a moment, being attracted by a novel sense impression and is usually noisy and most restless at night and when alone. The malinger may declare himself to be insane unlike the true lunatics who scoffs at such an idea and is very insistent as to his delusions and hallucinations, both of which, if he were really insane, he would be very reticent about. Finally, the malingerer nearly always overacts his part, is inconsistent

and unlike the truly mad will not allow his attention to be attracted for an instant. If there is any doubt such a man should be kept under observation for some ten days or so, and watched very carefully at night. He will be found to be very quiet then and to sleep, and to soon take his food, rarely will he go to the length of requiring this to be given him by a tube which so often happens in the really insane. A course of feeding through a nasal tube with a strong emetic at the outset will, it may be here pointed out, usually cure any malingerer as will a course of seclusion with an exceptionally plain and restricted diet, a proceeding which certainly would not tend to ameliorate anyone really insane. Delusional insanity could scarcely be feigned without very easy detection for the true paranoiac hides his delusions, and these are of very slow growth, often requiring years for their development. What, however, sometimes presents a difficulty in the converse direction is a case of commencing Dementia Precox, *i.e.*, Hebephrenia, the sufferer from which may be suspected of malingering. Two such cases came under my notice. The patient sat simpering, occasionally chuckling and laughing, could not be got to explain himself or to occupy himself in any way, he was at his worst when visited, and when left alone usually sat quietly doing nothing. All the friends could say was that his conditions had supervened in about two months. The condition passed into obvious insanity a few weeks later, though at the time both patients were diagnosed as sane. It is, however, extremely difficult for any person to simulate causeless laughter and a similar symptom now would give me a strong suspicion of the nature of the condition.

What is still more difficult, however, are some cases of Cata-tonic stupor. A man accused of a crime is for sometime previously depressed, quiet and morose, not a condition, however, to attract much attention among natives. He commits his crime and after being arrested, seems as is natural only a little more depressed; but later on in the course perhaps of two or three days, passes into a state of stupor, is mute, motionless, perhaps dirty, asking for nothing.

Twice this condition has supervened in my experience after a sentence of death and the supposition to an untrained observer that it is feigned is very natural, especially when we remember that many of these people have very curious 'symptoms. If left alone they will occasionally move, cover themselves

with a blanket when they believe themselves unobserved, they will take food lying beside them and slowly eat it, but when visited they are at their worst, rigid, mute, and motionless. Their appearance, however, is characteristic, no amount of cutaneous stimulation, pinching, pricking or burning will induce any re-action greater than a mere flinch. Their skin is peculiarly clammy and greasy, the pulse very small, compressible and slow. The extremities soon become blue and cold, there is universal muscular tension (negativism) and any movements made is strongly resisted or, if this is less marked, there is at any rate rigidity of the neck muscles and those of the shoulders.

Patients will remain in this condition for a year or longer without changing, and though one must own that a medical man or attendant with fair asylum experience might conceivably simulate such a condition, it is more than unlikely that any one could have sufficient self-control to continue the imposture for such along period.

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## CHAPTER V.

### CAUSATION OF INSANITY.

This is often extremely difficult to ascertain firstly, because it is peculiarly difficult especially in this country to obtain any history at all, and secondly, because when one can be had it is very difficult to obtain a true one, but though insanity is undoubtedly most frequent in the most civilised countries\* all observers are agreed that in most cases in addition to an exciting cause usually a "moral" one for the actual onset, there is generally a predisposing (physical) one in the patient's constitutional tendency derived from hereditary influence, and in this particular the reader is referred to the Chapter on "Degeneration" in this volume. It is believed and stated that particularly as regards the indirect "moral" exciting causes of insanity, these would not be sufficient to cause such unless there were a tendency in the patient to be affected by them. This tendency being the result of the fact that in the person's ancestors there has

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\* According to the report of the English Commission on Lunacy, there were on the 1st June 1906, 1,21,979 people under certificates of insanity.

In Scotland there were on 1st January 1906, 17,450 insanes and in Ireland there seems to be now some 25,050.

been either insanity itself (in which case often exactly the same variety is transmitted) or some disease, diabetes, chorea, migraine, asthma, hysteria, epilepsy, moral degeneration, alcoholism or other evidence of hereditary degeneration. Insanity is the most hereditary of all diseases—no one means, of course, to say that every insane person will have insane children, but there is certainly a tendency for such to be handed down by them, and this is the greater in parents with this disease when correlated and similar in disposition; sometimes indeed their children escape, but the tendency appears in their grandchildren. (It is said that the mother is more likely to transmit the disease to her daughter and the father to his son, though the relative danger of its transmission by either father or mother is perhaps almost equal, on the other hand it is said that personal resemblance and central defects and tendency to disease are not usually transmitted by the same parent.)

To revert we may conclude that predisposing and exciting causes are both necessary, roughly the predisposing are usually physical, the exciting frequently moral ones. Some causes, however, may be both predisposing and exciting, such as syphilis and alcohol. The moral causes are said to be more effectual (they are certainly more frequent) in the more "civilised" countries.

In passing, it may be here remarked that it is always necessary to be careful that the first symptoms of mental disease are not mistaken for its initial cause. The first and fundamental change in insanity is, of course, that a man loses his self-control and may give way to drink or to vicious courses and by a careless observer, this first symptom may be described as the actual cause of the disease.

The subject is further obscured by the fact that when we see it appearing in successive generations, from the hereditary taint being extremely potent, it tends to appear earlier and earlier in life and from slighter and slighter causes.\*

Perhaps the best way to classify the causes is to arrange them as done by Dr. Mercier under the heads of Heredity and Stress.

A. Heredity (i), the presence of insanity, nervous disease, etc., in the parents.

(ii). The existence of alcoholism or syphilis in them.

(iii). Tubercle in the parents which is undoubtedly a very powerful factor in creating a tendency to insanity.

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\* A child generated during alcoholism is extremely likely to be an idiot and an infant of syphilitic parents may be affected with Juvenile G. P. I.

(iv). Great difference of age between the parents, especially if one of them is of advanced age.

B. The stresses which may be of two kinds, direct and indirect.

A. *Direct diseases*, such as tumour, abscess of the brain.

(1). Cerebral hæmorrhage or injuries, inflammation of the brain and meninges.

(2). Toxins circulating in the blood and autotoxins which many suppose of very wide influence: as septicæmia.

Fevers, all the exanthemata and pneumonia.

*Charas* (Indian hemp).

Opium—*more than doubtful*.

Alcohol.

Lead.

Cocain, chloral.

Mercury.

The direct stresses it may be added are the only ones likely to cause insanity in a person not predisposed to it by hereditary tendency, but there are also others such as epilepsy, heart disease, asthma, gout, etc., which are in themselves both predisposing and exciting causes. Alcohol, of course, is a direct and indirect stress.

B. *Indirect Stresses*.—These act more readily in the unstable, *i.e.*, the predisposed persons than on others; indeed in the case of some of the more frequent, such as worry and anxiety, it is very doubtful whether they could produce insanity in a person not predisposed to it by the existence of a nervous heredity.

These indirect stresses consist of—

(i). Anxiety—worry, financial and domestic difficulties, fear and fright, disappointed affections, etc.

(ii). Over-education especially if combined with insufficient exercise and bad hygiene.

(iii). Intemperance—

Alcohol is a very important cause, either directly as a toxin or indirectly by its leading to want and worry, and its influence in causing degenerate, vicious and idiotic children is indubitable.

There can, however, be no doubt that drinking in pursuit of pleasure in the well-fed, well-to-do is far less liable to cause insanity than when it is indulged in as a method of relief from despair and misery by



the ill-fed, emotional and neurasthenic or neuropathic individual.

- (iv). Syphilis.
- (v). Sexual excess.
- (vi). Overwork, especially if this is unsuccessful, it is rare to see it follow excessive labour if this brings great success, except perhaps over-study under bad hygienic conditions such as is seen in India.

In Europe, it is said, that domestic worry more frequently causes it in the female, and commercial, pecuniary in the male, but in this country one sees that the most frequent cause in both is worry connected with family—the loss of several members of it (as by plague, etc.), with the male the publicity of wifely infidelity. Religion is not a *cause* of insanity unless it is so indirectly by producing loss, worry, anxiety or exhaustion as in those who change their faith—“religion.” In many, however, and often it is a first symptom.

It is very clear indeed that worry and constant anxiety are pre-eminently the indirect causes of insanity.

Masturbation is usually an early symptom and not a cause.

- (vii). Insanity is peculiarly frequent at any of the marked epochs of life at the commencement of adolescence, at the climacteric in women, at the period of involution and in advanced old age in both sexes.

## CHAPTER VI

### INFLUENCES OF SEX AND AGE.

In this country the objection to allowing females to leave their home is so strong that most cases are retained there and the number under treatment, or even seen is very small, while the mortality among them (the weaker sex) is larger, it is, therefore, impossible to say whether more or fewer women become insane than men. In Europe more females are under treatment, but there are more women than men and the fact of menstruation, child-bearing lactation and the “change of life” exposing them to many risks.

stresses and sources of worry and anxiety, explains that insanity more frequently happens to them individually.

In India an additional distinction is brought about by the frequency of insanity from the excessive use of Indian hemp, this is a habit practically unknown among women and they therefore escape the disease.

### THE INFLUENCE OF AGE.

Idiocy, the failure of mental development or evolution is, of course, the variety of insanity in the child, just as Dementia (mental dissolution) is that of old age. Though very occasionally we see acute mania (or rather an exhaustion psychosis) in youths or young girls; it may be said roughly that insanity does not occur until puberty when at the onset of adult life, there is a special liability to it. This liability then continues at all the great crisis of life *in women* at the onset of menstruation with child-bearing, lactation and again at the climacteric. *In men*, at puberty, adult life with its attendant, worries, the anxiety of marriage and the cares of family, in middle life cause it from the same reason. All through life there is the liability to it from toxins and direct stresses and again in both at old age when with the decay of vitality, in both the organism is less able to withstand the various stresses affecting it. Probably the maximum amount of insanity occurs between 20 and 30. It is said to be predisposed to by celibacy, but this is probably capable of other explanations.

The more marked is the nervous inheritance in the parents, *i.e.*, the greater the tendency, then the more likely is insanity to appear early and curiously enough, there may even be a tendency handed down from parent to offspring for mental disease to appear at exactly the same age.

It is doubtful whether there is such a thing as an insane. Diathesis or Temperament (Temperament is usually taken to mean the sum of a person's mental characteristics and Diathesis, the bodily condition, the morbid constitution predisposing to the development of a particular disease). Certainly there is an hereditarily transmitted tendency to insanity, and this is the most important factor of all in its production.

This tendency is shown not only by the liability to mental disease itself but by the presence in so many of these people of the other evidences of degeneration. Such are the bodily peculiarities

known as the stigmata of degeneration common to them and to such as idiots, moral imbeciles, epileptics, hysterics, neurotics, the one-sided genius, the criminal, the prostitute, the pauper, the congenital deaf-mute and those born blind.

Though any of the stigmata may be present, a certain number are more commonly met with than the others. There are, of course, no abnormalities of head and body peculiar to insanity, and certainly here one meets with cases chiefly of toxic insanity, in which to the naked eye there is no discernible cerebral or body defect, but on the other hand in the vast majority it is common to find them and relatively far more frequently than in the sane population. It is possible to have insanity in a man of good physique and appearance and especially is this seen (for some obscure reason), most often in Pathans, speaking broadly, however the bodily size is below the average and short stunted individuals of pure physique are common. It is extremely rare to find a good-looking man or woman in an asylum (beauty is unknown even among the women), and even should such exist at the beginning of the illness, their mental derangement almost invariably so alters the appearance and bearing that it becomes unlike sane individuals and the facies is always at the least peculiar.

As regards the more local stigmata, as some anatomical change or defect of the brain, it is reasonable to suppose is undoubtedly the basis of the majority of the cases of insanity, it is not surprising that these are chiefly seen in the head and cranium.

(1) The skull may be larger or smaller in all dimensions than the average healthy sound-minded individual, such peculiarities being most frequent in idiots—it may be so small though otherwise not misshapen as to attain the dimensions characteristic of microcephalic idiocy. It is believed that a circumference below 17 inches is incompatible with ordinary intelligence—one of 13 or even less may be seen. It may be extremely large with or without bulging frontal eminencies.

(2) The skull may be misshapen—the two sides may be unequal—(a) (a very frequent anomaly), so that a difference can be clearly seen during life or sometimes only after death when on the skull cap being removed it will be noticed that the median longitudinal sulcus is more to one side than the other, and that the grooves showing the course of the vessels inside markedly differ on the two sides. In the case of epilepsy following infantile hemiplegia there is almost always a marked deficiency of

one side of the skull contrasting with the other and readily visible to the unaided eye.

(b) (i) There may be a marked flattening at the occiput said, I do not know with how much reason, to be very frequent in those suffering from folie raissonante ; (ii) less frequently is there the same of the frontal bone ; (iii) or the vault may be extended backwards and upwards in a very prominent manner ; (iv) or the median line of the skull anteroposteriorly may be raised in its entire length so as to produce a scaphoid keel shape.

(c) There may be extreme brachycephaly or dolicocephaly—extreme width between the ears and from occiput to frontal bone or there may be apparently a general disproportion between the dome and the base. *As regards the face* this may be irregular as a whole or one-half of it smaller than the other, so that the nose seems to project one side and the mouth to be drawn up at one corner. This is an extremely frequent anomaly among insanes, epileptic and idiots. The nose *per se* may be distorted, stunted, flattened at the root, etc. The ears in the vast majority show some defect, they project out away from the scalp—are enormously large or unduly long or are “set on” at an unusual angle there may be one or several Darwinian tubercles, the tragus wanting the helix not properly shaped and the lobule bound down. In women, of course, the ear is in sane and insane alike distorted by their habit of carrying such an enormous number of ornaments on it and gives no information. Though not a stigma hæmatoma of the ear is said to be a very frequent peculiarity of the insane, it is certainly often seen but will almost always have been found to follow injury or violence, the only efficient remedy it may be added is blistering it.

The teeth are often irregular, doubled separated by wide intervals, frequently foul yellow and badly shaped, prominence and undue length of the canines is especially common. In this country where beautiful teeth are so usual, this anomaly is a very striking one.

A high degree of myopia is not at all uncommon and the occurrence of pterygium in one or both eyes very frequent. The palate often presents peculiarities, the two sides unequal, or it is high, narrow and keel-shaped or unusually wide.

Anomalies of the limbs are not uncommon, extra fingers or toes, undue length of arms, flat feet and as Stoddart used to point out many cases of Dementia Præcox have the thumb looking in

the same direction as the fingers, and an undue flattening of the thenar and hypthenar eminencies. The deformities of hemiplegia are frequent among imbeciles. Sexual anomalies are not unknown—unusual growth of hair which may cover its entire body (baldness is very rare except from disease among insanes), sebaceous cysts are very frequent with various other anomalies of less common incidence and epileptics, of course, often show traces of injuries received as a result of their fits, and among idiotic children, large numbers are seen with every variety of Diplegia, and in later life with the result of infantile paralysis, while all forms frequently show various forms of strabismus and nævi leucoderma often supervenes in later life and every variety of insane is particularly liable to become infected with tubercle. When with these congenital anomalies and tendencies are conjoined the peculiarities of expression and bearing imprinted by the several forms of insanity, the marks of injury from self-violence and that of others, the scars on the head and limbs and marks of burns so common among epileptics there results a whole which cannot fail to strike any one even on first visiting an asylum.

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## CHAPTER VII.

### CLASSIFICATION.

The pathology of mental disease has not advanced far enough to enable us to classify insanity as it should be according to its causes, and the result is that we are usually forced to have recourse to a mixed classification and also for that reason too almost every writer and they are many, gives one of his own. I regret not being able to form an exception or to be able to provide more than a purely clinical division which though in accordance with experience is not, I admit, a scientific one.

Insanity may be congenital or acquired.

A person mentally deficient from birth or early infancy is spoken of as an idiot if less seriously affected as an imbecile or as simply weak minded. A few are simply *moral* imbeciles.

All the remaining varieties of insanity are acquired.

Of the large majority of these latter, the most striking differences range themselves in accordance with the oldest classification of all than which nothing better has yet been given and which only omits a few certainly notable exceptions. This is mania, melancholia, dementia.

That is to say that an insane patient is either *maniacal*, i.e., excited, exalted, happy, garrulous, self-confident, noisy, boisterous with a rapid flow of ideas, or he is melancholic, depressed, apprehensive, furtive, silent, oppressed with an overwhelming sense of fear and insane dread. Either of these varieties may be acute and transitory or chronic or recurrent. Finally as a result of long continuance of either of these, and in some other instances he becomes demented, his mind is gone, he becomes a weak mindless tool, obeying anyone, void of memory, volition, desire or initiative; the counterpart of an idiot only that the latter has been void of mind all his life, while a dement has become so as a result of disease, indeed one may call the first amentia, the second dementia.

Each of these has different sub-divisions to be described when dealing with each. One particular variety of the first, acute delirious mania being there is reason to believe a distinct entity.

But beyond these, certain diseases by the exhaustion they produce, cause indirectly a form of insanity usually of acute onset and rapid course attended with psychomotor excitement, plus peculiar and easily distinguishable symptom chiefly those of confusion and disorientation, such follow certain fevers, the exanthemata or pneumonia, although they are practically indistinguishable from some forms of insanity arising from exhaustion, from any cause, starvation, great moral shock, prolonged lactation, etc., and also from that arising during the course of fever and blood poisoning. Though these latter are distinguished by some as infection psychoses—it seems almost better considering this similarity of symptoms to group them all under one head, that of their cause and to term them exhaustion, psychoses or as some naturally anxious to give an explanatory name would have it confusional insanity. Then some of the conditions are dependent on a toxin or drug poison, alcohol in Europe being the chief, whereas in this country that place in causation is taken by Indian hemp, the rarer are opium, though this is very questionable, cocaine, lead, etc., all which we may class under toxic insanity.

In the female so many of these conditions arise in connection with child-bearing, that almost all writers make a special division of insanity of pregnancy. At the age of puberty and commencement of adult life, there is a well marked form of mental disease with special features termed by some *Dementia Præcox* and by others adolescent insanity. Again insanity is so frequent at the

climacteric in women and at a similar age in men, that a climacteric insanity is spoken of, while some predisposed people break down at the period of involution ; and with advanced old age, a typical senile insanity is met with. These several varieties may be grouped together as Epochal insanities.

The combination of epilepsy and insanity is so frequent and important as to necessitate its being considered in a class by itself. Apart from all these, however, there is a very important division of insanity in which with the mind apparently otherwise clear, there is a delusion of a very coherent character, a systematized delusion of a long duration unattended for years by almost any other mental symptoms, except great suspicion and later hallucinations. This is commonly known as chronic systematized delusional insanity or more tersely as Paranoia.

Insanity follows paralysis, hemiplegia, etc., frequently enough and with such distinct features as to permit some to speak of a paralytic insanity, though these can come more properly under the head of organic dementia. Over a great part of the world is found a special disease not seen in Indian natives always comparatively rapidly fatal, known as General Paralysis of the insane or G.P.I. Finally, I personally from its legal importance prefer to class apart those persons whose weakness of mind is restricted to loss of the moral sense, *i.e.*, the power of acting rightly such are generally cases of moral imbecility though for clinical purposes a certain number of others are included with them under the term of moral insanity, where disability is the result of previous insanity or is conjoined with some other affection.

Equally important are these cases characterised by uncontrollable insane impulses usually spoken of as impulsive insanity.

Just as almost any physical disease is met with among the insane, so mental disease not unfrequently appear in those already bodily affected, such as with Tubercle, Asthma, Gout, Diabetes, Chorea, Influenza, Myxœdema, Crétinism, Rheumatism or Heart Disease, Malaria, Sunstroke and Syphilis. The features, however, are not sufficiently distinct to permit of their being described together, nor is the conjunction so very frequent, nor is the relation of cause and effect, so certain as to force us to elevate them into a special class of mental disease except for the purposes of description and the same may be said of the conjunction of Hysteria and Insanity.

The classification, given overleaf in accordance with these remarks, has no pretence to scientific completeness, but it is claimed that it is a convenient method of arranging the types of insanity usually met with in practice at least in this country.

#### CLASSIFICATION OF MENTAL DISEASE.

##### A.—Congenital.

Idiocy, imbecility, weakmindedness, moral imbecility.

##### B.—Acquired.

1. Mania.
2. Melancholia. } Acute, recurrent chronic.  
                           1a acute delirious mania.
3. Dementia.  
    Acute, secondary organic, etc.
4. Paranoia or chronic systematized Delusional Insanity.
5. General Paralysis of the Insane.
6. Insanity with Epilepsy.
7. Impulsive and Obsessional Insanity.
8. Exhaustion psychoses (Confusional Insanity).
9. Toxic Insanity. { Alcohol.  
                           Indian hemp.  
                           Opium and morphia.  
                           Lead, cocaine, etc.
10. Epochal Insanity.
11. Adolescent—Dementia Præcox.
12. Climacteric.
13. Involutional.
14. Senile.
15. Paralytic Insanity.
16. Moral Insanity.
17. Insanity with Physical disease.
18. Puerperal Insanity.

#### CHAPTER VIII.

##### IDIOCY, IMBECILITY AND FEEBLEMINDEDNESS.

When from childhood the mind fails to develop, the bodily organs developing, but the mind not, the condition is termed Idiocy—in such a case there may be practically no mind at all;



the child sees but does not perceive ; hears but does not understand ; is often unable to speak ; cannot care for himself, dress or feed himself, and is incapable of being taught to do so. A lesser degree of this in which the child can be made to understand and can be taught to a certain degree is termed Imbecility, while a still higher degree in which the infant grows to an adult, but his mental development remains that of a child with a knowledge out of all comparison inferior to that of his capacity for ordinary affairs, is usually spoken of as weakmindedness, and there is really every grade between these three—all are a result in failure of cerebral evolution.

The idiot seems to be devoid of all the attributes of mind and to be incapable of learning, he can understand nothing ; often cannot speak ; is always wet and dirty like a little child and cannot be taught, in this respect. He is unable to protect himself, for many the food has to be put into their mouths, each has to be washed and dressed like a baby, and were they left alone, they would, if capable of walking, wander away, fall into fire or water or be killed by the first passing vehicle.

When an infant, it will be noticed perhaps that it cannot properly suck ; that it may have to be fed with a spoon ; never recognizes mother or nurse that it lies absolutely still in its cradle ; and in other words, that the ordinary microkinetic movements of infancy are wanting ; later on, it will be noticed that the teeth are late in appearing ; that he is very late in learning to walk and grasp—still later in talking, and if not always dumb, that his speech consists only of guttural sounds or noises or of a few badly articulated words or that it never rises above that of a little child even to advanced life—some will be able neither to speak nor understand ; others understand but cannot speak—these latter being more teachable. Stammering is common and the voice usually harsh and monotonous ; fits of violent uncontrolled passion are frequent, and the child cannot be taught proper control over his excreta, nor does this condition improve with advancing years. When fully developed, it will be seen that the majority have some physical stigmata of degeneration ; though the types vary in nearly all ; beauty is unknown except rarely in the higher feeble-minded, the expression is vacant, dull, degraded, bad tempered and forbidding ; devoid of any animation, unless it is the habits they often have of grimacing and careless laughter, while the awkward, clumsy posture and movements of their body and limbs, their waddling gait, the thick lips with often saliva

dribbling from them and their inability to move their eyes apart from their heads further distinguish them.

Physically an idiot is often of small stature the long bones curved with the head small or in some varieties unduly large and mis-shapen—unequal on the two sides the occiput flattened, the forehead receding low and the eyes often too close or too far apart. The palate high, narrow and arched; the teeth crowded and irregularly shaped. The lower jaw receding, the teeth readily decaying, the enamel defective, the ribs ricketty and the chest depressed. The ears may be defective, the lobe adherent, the rim or helix absent or the whole ear too prominent.

The head sometimes has some congenital malformation and the circulation is nearly always defective accounting for the blue cyanosed hands and feet. The former are often square and spade-like, the respiratory movements are usually shallow, the papillæ of the tongue are frequently hypertrophied and adenoids are frequent. The skin is usually harsh and dry and the hair brittle and defective. Pubic hair is usually absent and the beard in adults wanting. The nails brittle and ridged. The sexual organs often show some abnormality although masturbation and vicious habits are extremely common.

It must not be supposed that one and all of these malformations are seen in every idiot but they are very common—and it may be laid down generally that just as no idiot is handsome neither is he of normal stature or configuration. Mentally—they are very defective in power of attention—this being a faculty (*sic*) of late development—in the idiotic—it fails to be evolved, or even passive attention may be defective from defect of sensory perception—such idiots being quite unteachable. Sensation and ergo—perception being defective in many such beings. Apparently a higher minimal intensity of stimulus is necessary than in normal people. This is also seen in the defects of the special senses that are so common—many of them are deaf, others are blind 8% and tactile sense seems frequently lessened this apparently accounting for their clumsy way of handling and acting. Perhaps taste is perverted, for certainly idiots will eat filth and garbage—smell is said to be imperfect. In memory there is usually some deficiency, but at the same time it is usually among idiots that the cases of remarkable memories for one particular line—figures, dates, etc., are seen—just as in the same way some exhibit a wonderful power for music, though at the same time this is purely

an "ear" facility. They are quite incapable of being taught to read music. The absence of speech in so many too has an important effect on memory. It is said that space and time perceptions are deficient and they certainly seem to be so. Ordinary sentiments and affections are absolutely wanting, except, in the very highest of the feeble-minded type, yet some idiots appear to have a liking for one particular person—in moral qualities—the highest evolution of mind—they are absolutely wanting. If able to speak, they have no idea of truth or right and wrong and no real religious education is possible—they are irritable, intolerant, have no regard for others, are subject to violent passions—will steal, injure those weaker than themselves—commit sexual crimes and deeds of violence, (arson is very frequently the crime of a feeble-minded person) and they often show great and even feindish cruelty to animals and children. Though it is true that a few are quiet and docile. Nearly all are destructive and quite unteachable, never learning not to destroy or burn just for the pleasure the sight gives them. This is shown even more clearly in the people who are only feeble-minded—these have no sense of honour nor regard for anyone but themselves—are vain, and whereas the deep grade idiot will go naked, these may be absurdly dressed—they yield to gross dissipation, become the tools of designing people and simply give way to their lower instincts. Shame as a sense is quite unknown, and none ever occupy themselves of their own free will in any useful employment. In all these details there is, however, it must be remembered, great difference, some may be always wet and dirty and yet fairly bright and teachable. Indeed, some may be only termed weak-minded from these very errors of conduct—whatever they may be. It is a sound principle that they should never be left without control. Many exhibit some curious habit—the body may be swayed from side to side—the tongue constantly jerked by the hand, curious ways of hiding the face, stroking the nose and eyes may be noticed as well as some involuntary movements of the hands and fingers somewhat resembling those of athetosis. Co-ordination is always faulty and the finer adjustments of muscular action difficult, and the movements almost invariably clumsy. Grimacing and vacant laughter are very common. Special varieties exhibit almost every kind of paralysis, perhaps the most common being diplegia and hemiplegia.

The varieties usually explain practically the causation of many, for we speak of (1) Microcephalic Idiocy when the head is unduly

small. Roughly, anything below 17 inches in circumference may be said to always entail idiocy. A special race of these (familiarily known as Shah Daula's mice) exists in the Punjab, many of whom have extremely small heads, 13 inches, circumference in an adult being quite common, most cannot speak, are remarkably small in stature, squint is frequent, as are the ordinary signs of defective intelligence, while the ears are placed at almost right angles to the skull. Many of this particular type are very active and restless, though usually harmless and docile, a large number indeed being merely imbecile.\*

(2) *Hypertrophic Idiocy* when the head is enlarged: in these the brain is of greater size than normal, due to an increase not of nervous tissue but of neuroglia.<sup>†</sup> The head is usually square-shaped or elongated anteroposteriorly, the greatest width being over the supraciliary ridges. This variety is rare, the children are slow, heavy and dull, often complain much of headache—it must be remembered that many normal children have very large heads.

(3) *The Hydrocephalic Idiot*: this also shows a very large head, indeed the largest of all, but is quite a distinct variety from the foregoing. It may be congenital or acquired and also acute or chronic, and often causes early death preceded by blindness and deafness, the patient in the late stages making a pitiable picture with the almost translucent skull of enormous size with bulging fontanelles contrasting greatly with the shrunken tiny body and the paralyzed legs drawn up in a condition of sclerotic rigidity under it.

The hydrocephalic head is round, of the same width transversely as anteroposteriorly or else widest at the temples with an increased distance between the eyes—the ricketty head is sometimes mistaken for this, but it is longest anteroposteriorly and has the fontanelles depressed.

(4) *The Epileptic*.—In these cases the fits have usually begun in early life during dentition, idiocy appearing concurrently—in case of infantile hemiplegias weak-mindedness is early and the epilepsy only commences about the age of 12 or later.

(5) *Eclampsic*.—This is a form of idiocy or rather imbecility which follows severe convulsions in early childhood—many infants have “fits” without subsequent mental damage, but in others these may be of so severe a character as to cause permanent damage to brain tissue—such cases have no power of fixing their

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\* In the appendix is given a short history of these people.

attention, are very excitable and grow up to be most mischievous and passionate.

(6) *Paralytic*.—These include the various varieties of cerebral diplegias and the well-marked variety that follows on infantile hemiplegia—these latter always develop epilepsy about puberty or before and the majority of the former suffer from convulsions sooner or later.

(7) Traumatic following on an injury to the skull, a fall, a prolonged pressure on the skull during labour or by instrumental injury at that time. These latter being of very profound degree, whereas when a child has been normal up to the time of a fall or injury, then only a slight degree of weak-mindedness results, chiefly shown in the normal capacity, usually also plus a peculiar defect of fixing attention which perhaps accounts for the fact that these children are extremely unsusceptible to training, more so even than congenital idiots.

(8) *Inflammatory*.—Certain fevers, scarlet, typhoid, measles, and whooping cough are attended with inflammation of the brain and membranes which causes imbecility.

(9) *Syphilitic*.—Inherited syphilis is said to produce this result in some, but it must be of rare occurrence.

(10) *The Mongolian Idiocy*.—This is a congenital type less common here than in Europe—the facies is peculiar, the orbits appearing lowest at the inner canthus and the eyes occasionally oblique, the head small, the features broad with the nose flattened and the figure squat and small, while the hands are peculiarly flat and spread out, blue and cold, the tongue showing hypertrophy of the papillæ. Dentition is particularly late. The skin is curiously harsh, many have organic heart disease, though curiously enough, nearly all die about the age of 20 of phthisis—they are always of a very low grade of intelligence but generally cheerful and docile.

(11) *Genetous Idiocy* includes under this heading all those idiotic from birth and not belonging to any of the former classes. There is usually marked hereditary taint, nearly all are dull and degraded, with clumsy shuffling walk, short stature, high palate, bad dentition, large disproportionate ears, indeed showing nearly all the stigmata already alluded to. The general health is poor. Rickets and Phthisis common.

(12) The cretinoid is a special type—it is a congenital myxœdema due to absence of the thyroid. The child is at first

normal but soon changes; he is short, dwarfish with slow retarded growth, deficient short brittle hair, a dry harsh yellow skin, sunken eyelids, flattened head and nose, the lips and tongue thick, very bad dentition, protuberant abdomen, a flabby ill-developed sexual organ with defective speech and harsh voice—there is usually a mass of fat forming a distinct swelling above each clavicle, the temperature is always sub-normal and there is great susceptibility to cold—they are usually good tempered, but of poor intellect. These cases are susceptible of wonderful improvement by thyroid feeding though they relapse immediately, this is discontinued.

(13) Idiocy by deprivation is the term given to that form of imbecility resulting from congenital deficiency of one or more senses. In this country one born deaf and dumb has no training and is of necessity wanting in ordinary intelligence, but unless the defect is a cerebral one, these cases are very amenable to efforts at teaching and show quickness and an aptitude for learning.

## CHAPTER IX.

### THE CAUSATION OF IDIOCY.

#### Parental—

- (1) Direct transmission.
- (2) Parents being insane or afflicted with nervous disease.
- (3) Tubercle in the parents.
- (4) Parents aged or degenerate.
- (5) Alcoholism at time of generation.

#### In Utero—

- (1) Injury to mother.
- (2) Shock or fright to mother.
- (3) Severe illness of mother.

#### CAUSES OPERATING—

##### During labour—

- (i) Compression.
- (ii) Asphyxia.
- (iii) Injury from forceps, etc.

{ Most probable with first-born children and to a lesser extent with twins.

#### AFTER BIRTH.

- (i) Injury to skull.
- (ii) Inflammatory following fever.

- (iii) Infantile convulsions.
- (iv) Infantile diplegia and hemiplegia.
- (v) Cretinism.
- (vi) Hydrocephalus.

In a large proportion a neurotic inheritance from the parents of insanity, epilepsy, alcoholism or syphilis will be found, and this inherited factor is undoubtedly most potent. Though almost all idiots are incapable of procreation and child-bearing, still this does not hold in the milder varieties of imbeciles and weak-minded persons, and in this case the inheritance may be direct, *i.e.*, imbecile mothers may have an imbecile or idiotic child—this is nearly always so in the case of the microcephalic Shah Daula's mice of the Punjab.

Quite 20 per cent. of idiots have a history of Phthisis in the parents.

Syphilis is not a very potent factor; inherited syphilis either kills the infant or should he survive to adult life, juvenile general paralysis may supervene, but certainly a few cases apparently due to syphilis have been recorded, and it is said that this is especially likely to happen if the mothers contract syphilis during gestation. Alcoholism on the other hand has undoubtedly a powerful agency, and there seems strong ground for the belief that the product of a drunken conception is often an idiot.

The child of parents of advanced life is sometimes mentally deficient, and the same may be said of the last child of a large family; experience in India does not bear out the assumption that the same holds of the offspring of marriage in very early life—this is the rule in this country, idiots are rare and healthy offspring from such union, as everyone can testify, very plentiful.

A pregnant woman, the subject of some severe shock, fright or accident may give birth to an imbecile child even if she be free from any insane inheritance, and this is still more likely to be the case in those of "neurotic" families.

During labour the child may be subjected to injury from prolonged compression either in the maternal passages or very rarely by instruments, and this accounts for the fact of their being more male than female idiots, and more of first-born children; it is said that half of all idiots will be found to be "first born."

The causes acting after birth do not need any explanation.

Fortunately for themselves idiots rarely survive to old age, and it is only by the use of constant trained supervision that they

are prevented from ending their miserable lives earlier from some of the many accidents, their helpless condition exposes them to—even good surroundings and unremitting care cannot usually save them from early phthisis or the result of constant epilepsy from which so many die.

As a whole, they may be regarded as the ultimate product of degeneration of a race or family and intellectually as beings living on a perceptual mind level, the higher intellectual factors such as judgment, comparison, memory and will; indeed, everything above mere sensation and reflex action being practically non-existent.

Easy as they usually are to recognize, cases sometimes do arise when it is necessary to decide whether a youth or adult found wandering about, of whom nothing is known, is an idiot, or in a state of chronic mania or demented or stuporose—usually a history even failing, the diagnosis can be made from the speech. The insane, it can be seen, understands what is said to him, has memory of past events and in conversation is either incoherent or may show the existence of some delusion or hallucination; an idiot shows none of these characteristics. Nor, on the other hand, is an idiot liable to mania, etc., though he may frequently show outbursts of passion or irritation. It has however been stated that some simply weak-minded people are liable to insanity chiefly to that form described by some observers as Katatonia.

No case among natives of India that might be placed under this heading has ever occurred among the many idiots, imbeciles and weak-minded people that have come under my observation.

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## CHAPTER X.

### MANIA.

It is unfortunate that in popular language any insane person is frequently termed a "maniac," whereas "mania" is really that form of insanity—by far the most frequent of all, especially in this country, characterised by great emotional exaltation, a rapid flow of ideas, hilarity and motor restlessness—being the most easily



recognisable of all forms of insanity; it is the form associated in the popular mind as typical of mental derangement. All the other nervous and mental functions seem exalted with it. It is sometimes described as a "passion arising from disease," a derangement of the irascible emotions rather than of the intellectual faculties, and certainly, though there is just as often simply exhilaration and uncontrollable excitement rather than anger, the patient is even then truly emotional in the usual acceptance of that term, he becomes angry on the slightest opposition and may be equally easily excited to laughter or to tears. From the intimate interaction of one department of the mind with another, it follows that even if the origin is disorder of the emotions or loss of their control rather—the whole mind suffers in consequence and correct thinking, judging and reasoning is during the period of illness impossible. With the mental exaltation and bodily excitement there is complete loss of self-control, and it is this latter, the loosened inhibition, control of mental and bodily action which is the typical and fundamental feature and which gives the key to the entire congeries of symptoms characterising this disease.

No careful observer can fail to be struck with the intense likeness many of the cases bear to the symptoms of alcoholic intoxication in which also is seen the loss of self-control, and the laying open of the unrestrained passions until the natural self of each man, unrestrained by any sense of politeness and training, is laid bare—in *vino veritas*.

If a case of mania is seen from its very commencement there will generally be found to precede its actual outbreak a period of depression when the patient is gloomy, has a sense of impending illness or of mental discomfort which he is unable to account for, of tension in the head, he cannot sleep, digestion is disturbed, the tongue is furred, and he is constipated, has no appetite, the temperature is often a little raised, he finds a difficulty in concentrating his thoughts and notices great physical and mental prostration. Gradually all this is lost, just as unaccountably the appetite returns, he has a sense of extreme well-being which quickly becomes exaggerated into foolish cheerfulness and a feeling of extreme good health and increased power of heightened, quickened thinking and power of action, and in a few days or hours the true typical condition of acute mania sets in.

In this the predominant characteristic is, as already said, loss of inhibition, and it is this which allows the ideas to flow more

rapidly than during sanity, to be more easily divestible and to be without any guiding "end" or motive, and to permit the more unrestrained "fancy" and the action in response to idea.

The perceptions seem more active, there is general bodily and mental hyperæsthesia if one may term it so. The mental association of ideas is more quick. Instead of being as normally restrained by reflection and judgment, they pass one into another and into action, and hence the rapid speech, the restless movements of body and facial muscles so characteristic of this disease. The ideas are diverted, changed by every slightest sense impression and sound association, and hence any sustained line of thought and action is impossible. The patient is often in high spirits—very hilarious, perpetually talking, laughing, often shouting and screaming in a high state of excitement or anger, moving about from one place to another, waving his arms about, their movements being peculiarly rude and discursive and of the proximal joints in contradistinction to those of melancholia where these are slow, restrained, with marked rigidity of the shoulder, hip and neck joints decreasing to be least impeded at the peripheral articulations. His imagination and fancy seems so active that he cannot even keep pace with his ideas by speech however rapid, and he will break off one sentence to begin another. Having no self-control, he will do anything of which the idea occurs to him; the sudden idea suggested by some passing fancy is acted on at once. Often it seems as though a request made arouses its opposite, for if asked to do anything, he will often do exactly the reverse and in any case will only comply if it happens to please him or if the request is sufficiently striking to arouse his disordered attention.

The speech is that which strikes an observer most prominently; it may be (1) in simple mania rapid, and that of a man excited, self-satisfied, self-willed and full of belief in his own powers and abilities—it then resembles that of the early stage of intoxication, accompanied as it is by flushed face and congested conjunctiva, quickened breathing and pulse, a dislike of all control and interference—varying too with the natural disposition of the patient from this to a foolish excess of friendliness and tendency to extravagance or unjustifiable benevolence and familiarity to irascibility and aggressiveness.

2. In the more violent and acute mania the speech may be very rapid, full of sentences begun and never finished or made up of cries and shouts evidencing the great excitement and passion, in

the country often being simply causeless, foul abuse of anything and everybody.

3. It may seem simply incoherent—I say seem so, for it is very rare as a matter of fact that the speech of a true mania is incoherent; it seems so often from our inability to follow the working of the patient's mind, the course of his ideas, etc. The more one examines these cases closely the more one agrees with the masterly description given of them by Savage, and the more often it will be found that there is a true connection of ideas and that these pass simply very rapidly without any controlling influence from one point to another, there is no leading idea, no "end" or "object" to the train of thought. A man begins a sentence, the next idea may be aroused by the sound of the word (it is astonishing how many lunatics rhyme), for example, a phrase ending with "neck" will be followed by another beginning with check, etc., etc., man with can or the meaning of the last word will start another association; "children" will cause a flow of words having reference to family, then to wife, then to home, then to land, then to crops, etc., etc., or this then in its turn arousing verbal association to a word similar in sounds.

In but few is the attention sufficiently under control to enable them to answer a question, they will begin but usually rapidly wander from the point.

The patient is never still, but his energy is purposeless and like his ideas discursive and divertible, he rushes wildly about, his facial muscles are in constant movement, he turns at the slightest sound or indeed any sensory stimulus, he is hyperæsthetic—the slightest touch causes a reaction, he tears off his clothes, will go naked and even if he may not be as so many of them are wantonly destructive, the slightest impediment will cause him to tear them up—to break the doors that he finds shut, to tear and destroy the plants and shrubs he touches. Though destruction may also often be a result of his intense hilarity and sense of power and strength. By this time he is oblivious of all social and conventional restrictions; he is very dirty with dishevelled hair and disordered dress, he is defiant, regardless of anything, time, place or person—it is either impossible to attract the attention or to induce him to control it for a moment; he is changed utterly. The reserved chaste man or woman is familiar, loud, noisy, dirty and obscene. Often he may seem from disregard of conventionalities to be quick at verbal repartee, though at the same time any act requiring

intellectual concentration is impossible. Reflection has no time or power to exert its action; too often the natural man comes to the surface and all the passions run riot which may account for what is so often seen among the patients of the lower order in this country. Their filthy habits and obscene acts and language when maniacal and the fact that a patient will daub himself with his excreta, eat it, not necessarily wantonly but possibly from incapacity for attention and reflection. For the same reason, from the natural self being unrestrained, just as is seen in intoxication, where one man will pass from hilarity to savage anger, so in mania the patient may become irritable, combative and incoherent with constant angry excitement; there is always an incapacity to bear any contradiction and no maniac will admit the possibility of any one's judgment being superior to his own, but these particular cases become angry at imaginary affronts or mere interruption, and are often in that condition most dangerous, making sudden murderous onslaughts or inflicting severe injuries usually from want of reflection and from being without fear or knowledge of consequences, being just as ready to tear and rend a bystander as they are to tear in pieces their clothing and bedding.

A larger number perhaps are simply noisy, boisterously merry and good tempered, and though "maniacal," never wantonly dangerous; possibly on account of the variety of human disposition, the varieties shown are endless. One may be incessantly declaiming in a theatrical manner, another shouting in his rage, and another chattering apparently incoherently and without purpose, while in yet others the reaction to impressions and association of ideas may attain the rapidity of delirium.

Delusions usually of grandeur and exaltation of being some great personage and of possessing unbounded health and strength and capacity are often met with, especially in the cases of more duration, but from the general rapid association of ideas and their being free from "control" they are of a fleeting character and are never systematized as in Paranoia. The former occupation of patients much influence these, as for example a railway employé seen here, who passed his entire day at the wicket of his door, dealing with imaginary railway tickets and chattering in accordance with this idea.

At or from the onset hallucinations, usually of hearing, more rarely of vision and other senses, may be noticed, but these are not prominent and often totally absent in "idiopathic" acute

mania—hallucination especially of vision being very suspicious of a toxic origin of the disease, nor are they ever of the terrifying nature seen in *Delirium Tremens*. Undoubtedly there is a general hyperæsthesia of the senses, especially of the skin, yet except perhaps from the deficient power of attention, it is difficult to explain the manner in which some of these patients will remain naked in the coldest night, will disregard several self-inflicted wounds, or the way in which they will refuse food (the appetite indeed is very capricious; at one time food will be devoured voraciously, often in an uncleanly manner, at another all food is refused) so that one might be disposed to believe that the senses became blunted, but the extreme divertibility by any sense impression so characteristic of this variety of insanity, the way in which they re-act so readily to any skin irritation unlike a man with melancholia or stupor, is quite against this explanation.

Insomnia is almost invariable and is an excellent test of the reality of the insanity, for while a true maniac will shout, run, jump and move incessantly night and day for several days consecutively without a moment's sleep, the most skilful imitator is unable to do so for long without being overcome by fatigue.

The patients always lose flesh, even those who devour all given them voraciously and demand (as some do)—more incessantly—never gain in weight, the tongue is almost always furred and the pulse quickened, but the temperature, once the disease has begun, is not raised, the only exception to this being in acute delirious mania, an important point in the differentiation of this condition from the delirium of disease. Indeed, it must always be remembered that, despite the apparent strength and violence, mania is essentially a condition of weakness and that it always demands a constant supply of nourishment of good quality at frequent intervals, this indeed being the only and the essential treatment.

One may digress here to remark that it is extraordinary how the most severe wounds and injuries, even aggravated by the patients' habits (it is a common thing in this country to see a maniac tear off his dressings and fill a gaping wound with fæces) will heal ultimately, while on the other hand a physical disease, pneumonia, dysentery or diarrhœa is apt to end in sudden collapse and heart failure, while yet again it has been over and over again noticed that the advent of a severe disease, pneumonia, carbuncle, erysipelas, etc., will, if the patient survives, cut short a

prolonged case of mania that has up to that resisted all and every effort at treatment—and be followed by apparently complete recovery.

The facies of a person suffering from acute mania varies with the emotional condition; in those angry and violent, the features may bear an impress of fixed rage and anger, while in those merely exalted and joyous, the features correspond. In all these is a peculiar mobility of facial expression and a restless movement of the facial muscles, the most usual condition being a horizontal corrugation of the frontalis with a screwing up of the eyes which are frequently injected, at other times wide and staring and the whole face itself being usually flushed. The skin of the whole body is usually hot and dry, though the constant movement may produce sweating, but there is never the peculiar greasy beady condition so typical of melancholia. On account of the disregard of cleanliness there is frequently a bad odour though nothing typical, and the general condition of excitement and exaltation is rendered more characteristic by the disordered, often torn clothing, or the tendency some patients have to adorn themselves with rags, to tie pieces round their ankles, to replace their turbans with rubbish or to adorn themselves with fantastic articles in obedience to some delusion (usually a characteristic of chronic mania) and to rush wildly with almost handfuls of sticks, grass or shrubs they have just plucked, or morsels of food half finished, covered in dirt in their clothes.

The hair is always disordered and dirty; it is said to be stiffened, staring and erect, though personally it would seem that the total disregard to its proper care and attention is sufficient explanation of its usual condition in this country.

Finally, though the perpetual movement, worse at night, the rushing about, dancing, singing, talking, tearing and destroying, the speech denoting the rapid flight of idea are so typical of this disease, it must be remembered that there is a variety, at least in this country, of sullen, morose mania when a patient full of rage and usually most dangerous will maintain an attitude or motion for many times a day or will sit muttering silently with clenched fists and teeth without moving—generally in these there is some delusion of wrong or injury and a desire for revenge—a condition quite the contrary on the surface to that which is so characteristic of the disease, the divertibility even in the most irritable.

According to Dr. Craig\* the blood pressure is lowered in persons suffering from excitement or acute mania—while it is raised in those depressed or suffering from melancholia (the pressure returning to the normal after recovery) and that the pressure tending to fall during the day explains the fact always seen that an excited person is worse towards evening and at night.

The loss of memory for events during the attack is variable, and a distinct loss for long periods is very characteristic of a toxin poisoning or some profound exhaustion, or of an association with epilepsy, and in simple acute mania it will generally be found that at most there is a mere clouding of impression of what happened. In many the memory of the attack is perfect; a still larger number falsely declare it to be so.

Mania, especially the more acute forms, has a great tendency to recover under treatment. Though the duration varies greatly, some going on with intervals in which there seems to be a lull in the disease, followed rapidly by an exacerbation of all the symptoms for several months, there is every degree between these and those others which recover in a few weeks. Perhaps 25% in this country recover completely for the time being, a few, but very few under proper treatment die of exhaustion, and the remainder lose their more acute symptoms and lapse into a chronic condition in which they permanently remain and which will be described later—of those that recover an uncertain number are apt even after years of interval to suffer from a recurrence, though this is the less likely—if one may put it so, the more difficult it is to assign a cause for the original attack.

The names affixed by different writers to the varieties of the disease are endless and really of little value.

Mania may be of that character described as simple; it is more often acute, a varied intensity of symptoms the description of which has just been attempted, and this may become chronic both in duration and intensity, or it may be so frequently interrupted by remissions or followed by recurrence at short intervals as to be very correctly described as recurrent. Any variety of the acute may follow one of the indirect stresses and undoubtedly is at least a definite clinical entity. While there is also a well-marked acute, very fatal variety (probably a distinct disease), known as acute, delirious mania.

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\* Craig.—Psychological Medicine, p. 78.

But the maniacal condition may be a result of a toxin such as charas.

It may be a mania transitoria following intoxication or replacing Delirium Tremens in neurotic subjects, and the same may be seen after even a small amount of drink in those people who have recovered from sunstroke or severe head injury, such people, as is well known, being peculiarly susceptible to alcohol.

More important than all, mania may also be associated with epilepsy.

The condition seen after exhaustion, from fevers, sepsis, prolonged exhaustion from starvation, lactation or labour and many similar conditions, presents with predominant excitement peculiar characteristics, especially in the prominence of hallucinations and loss of comprehension of surroundings that mark it off from true mania.

Finally, a maniacal state is said to be sometimes met with in association with aortic disease, Graves disease and certain other ailments. We have therefore :—

*Mania* :—*a.* Simple.

*b.* Acute—chronic and recurrent.

*c.* Acute Delirious mania.

*d.* Mania transitoria.

*e.* Toxic mania.

*f.* Mania with Epilepsy.

*g.* Mania with other diseases.

It has to be diagnosed from (1) Intoxication, especially in this country, from bazar liquor. Many cases at first sight resemble mania, but as is well known by strong stimulation, a drunkard can often be recalled himself, his symptoms are only of some hours' duration and his period of violence and exhilaration is always followed by recovery or drowsiness, or if the amount swallowed is large, by coma, and there is also the history of its onset and the smell of liquor. On account of its frequency the acutely maniacal condition following on *charas* poisoning, needs special description.

(2) Delirium Tremens, which however it may be looked on by the public, is only a transient mania, though its special characteristics following on the patient's known habits, the peculiar fine muscular tremor and the fearsome visual hallucinations so characteristic in it of animals and vermin usually enable it to be diagnosed without difficulty—(a maniac it may be added is never afraid of his hallucinations). In books meningitis is also given as a disease that



may be mistaken for acute mania, but such must be a very rare occurrence in India. Meningitis is however usually preceded by rigor and headache and often vomiting symptoms unknown in true mania, as is also the fever which usually accompanies it. There is also often intolerance of light, rigidity of the neck, muscles and strabismus or paralysis, of all of which the same may be said, while there is not the same tendency to muscular exertion and movement and no true emotional disturbance, and the patient either quickly recovers or dies.

Acute delirious mania occurs usually in young people with well-marked neurotic inheritance—it is of exceedingly rapid onset without any preliminary symptoms and follows very frequently some well-marked cause such as intense shock, injury or grief. It is relatively more frequent in females. The temperature, unlike every other variety of insanity, is raised from the onset to 101 to 102, especially at night, but the greatest characteristic is the extremely rapid and persistent exhaustion, the intense prostration, the rapid feeble pulse, progressive emaciation and total refusal of food. It may be then mistaken for typhoid, but that such patients do not actually refuse nursing or to take nourishment, and the ordinary abdominal symptoms of typhoid are wanting and transient; visual hallucinations are common. With the extreme weakness there is even more restlessness than is met with in ordinary mania, and sleep is totally absent; there is constant severe delirium with incoherent (*sic*) chatter, the whole process indeed resembling the delirium of an acute fever. The patient lies on his back with flushed face, rapid breathing and pulse, in constant movement with jactitation, sordes on the lips and teeth and dry cracked tongue and obstinately confined bowels; bed sores are rapidly formed and later the fæces and urine may be voided involuntarily. Death is frequent in a few days from exhaustion.

The essential treatment is early and constant forced feeding. Such a patient must be fed at least every two hours except when asleep day and night, with milk, eggs, wine and brandy, strong soup, meat essences, etc., or any form of nourishment that can be administered in the only manner the restlessness and resistance of such patients permit of, namely, by a nasal tube or stomach pump. Drugs are useless, but with energetic treatment in this manner some cases may be saved and in cases of impending collapse large saline subcutaneous injection may be given. Whatever be the treatment, the disease is an extremely serious one.

Simple Mania (Syns. Amenomania, Partial Exaltation, etc., etc.) is met with usually in young adult life and exhibit a train of symptoms somewhat deceptive as such may be mistaken in those unacquainted with the patient's previous history for ordinary "wickedness," extravagance, libertinism, etc. In this country where it is so rare to obtain any trustworthy history of the onset and previous condition of the sufferer, such a mistake is very easy and justifiable. The patient is utterly changed from what he was before (though this indeed is the essential characteristic of all insanity); there is extreme and *persistent* high spirits, any cares or vexation before present are utterly forgotten even should these have caused his illness, are pooh-poohed and disregarded; the man is very talkative though the speech may be coherent and sensible, but it is persistent and accompanied with unnatural hilarity; he indulges in drink and women, becomes forgetful of ordinary politeness and conversational and social restrictions, is careless or extravagant in dress and appearance.\* The former quiet reserved chaste man is most strikingly changed; he becomes quick at replying, is extravagant and egotistical in his ideas (like all insanes); he formulates wild projects and ideas though incapable or neglectful of his own occupation; he is overbearing and is heedless of remonstrances, however much he may have been formerly amenable to advice and criticism and careful of public opinion. In short, he would resemble nothing so much as a careless, selfish, good-natured or brutal spendthrift with exaggerated ideas of self-importance and a constant desire to talk incessantly, but that this condition can be ascertained to be the opposite of his former tendencies and for the suspicious fact that his attention is very distractible, that there is marked sleeplessness or a tendency to awake early and a most capricious appetite and great restlessness, however many and good may be his wild projects, and such men are attracted by every passing craze; he cannot settle down to anything or carry on any one line requiring persistence and application for long. He is always bustling, talking noisily, though he can give a plausible reason for every change and is always full of self-satisfaction. He is lavish, foolishly extravagant, interferes with what does not concern him, full of schemes

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\* The emotions are however very unstable, a patient rapidly passing from hilarity to weeping, etc., this however being usually transitory, for the prevailing mood is certainly one of exaltation and self-belief, such patients being peculiarly intolerant of any suggestion that their opinions, statements and beliefs are erroneous. They are always self-willed and opinionated

for settling anything, and everybody and everything, writes to influential people or is utterly without self-consciousness and timidity. Yet with all that there is no loss of memory, no hallucination or loss of comprehension, and delusions, if the ideas of capacity and grandeur may be termed such, are very fleeting and changeable.

Such a condition may be only the first stage in an ordinary attack of acute mania into which it rapidly passes, but some cases are occasionally seen where nothing further is evolved and many such cases lapse into a chronic condition and do not recover. Their diagnosis is important both for the former reason and also on account of the need for young and rich people to be restrained as patients of this class will often give way to unbridled vice and squander, while in this condition, large sums of money, and do incalculable damage to themselves and their family; as to all ordinary people who have not, known them previously, they appear quite sane. Also though not usually dangerous, such people do certainly often show a marked facility for becoming very passionate over trifles and in that way aggressive and obnoxious.\* The diagnosis rests essentially on that which is a feature in all insanity, the fact, namely, that the patient is absolutely changed even if only in degree to what he was a short time previously. Often this is most marked in the affections, the sober, well-conducted man becoming dissipated and drunken without care for speech, person or dress. The prudent and careful individual, rash and extravagant or madly speculative. The pattern of morality and religion indulging without shame in dissolute habits, etc., forming with the typical insomnia and restlessness a whole which is most characteristic and also forming too another example of what is the essential factor of mania and indeed all insanity a lessening of self-control, the checks and restraints of former training, habits and connections being for the time all laid aside. Many such cases assume an extravagance of habit and conversation that may lead to a suspicion of their suffering from general paralysis of the insane, but the physical symptoms of the latter disease are wanting and the sufferers from simple mania are usually of younger life.

The *monomania proper* of Esquirol closely resembles simple mania, and indeed is in the opinion of the writer in this country

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\* Such people often appropriate anything and everything they see and may thus be charged with stealing.

absolutely indistinguishable. The cases described show a "quiet" mania and exaltation, the patient being full of his own beauty, graces, talents and station, looking only on the cheerful side of everything, very communicative and joyous, all being very irregular and obtrusive in their affections, susceptible and irritable, disliking opposition or interference and being quickly aroused to anger, and in fact showing the symptoms practically which are characteristic of simple mania.

In no sense on the other hand is the disease to be confounded (on account of the predominance of irregular or vicious habits) with moral insanity (or *Folie Raisonnable*) in which there is with this exception intellectual integrity and more or less capacity for following the ordinary associations.

Just as many patients during an attack of acute mania are wantonly destructive, and those in whom rage and violence are predominant symptoms will tear and rend everything about them, in the same way violence and injury to others is very frequently met with, and a maniac may murder anyone in this manner or from a resentment of interference, and it is these occurrences which have given rise to the term "homicidal mania," but such a variety is non-existent; homicidal and dangerous maniacs are of course seen, and there are insane people with a marked disposition to murder anyone or some one, but these form a different category and those in which murder is effected while suffering from true mania will be found to consist of (1) those who do so from a simple desire for destruction, (2) those who do so in blind rage, (3) or from some delusion that it is their right or duty or that they are conferring a benefit by so doing (such are however usually chronic manias), (4) those most common of all in this country who are in the state of furious mania produced by hemp drug intoxication: many of these cases would never probably commit the act, but that they suddenly come into some accidental possession of a weapon which suggests the act to them and causes the desire to use it. (5) In so-called puerperal mania coming on after delivery, the murder of the child is very common. (6) Lastly, we have the mania transitoria following or replacing, or preceding an epileptic fit, the most dangerous patients of all; these will stop at nothing, will place no bounds on the destruction of their victim and the injuries they inflict. One and all varieties have no accomplices; the victims are often those nearly related to them, wife, children, mother, brothers, etc., and very rarely is an effort made at escape or

concealment afterwards. It is characteristic of the absurdity of speaking of homicidal mania that as dangerous a class as any are remaining varieties of insanes who murder and who are not maniacal at all, namely, the paranoiac suffering from a delusion of persecution and the chronic melancholics who sit day after day, brooding over wrong, and are subject to fits of rage on trivial provocation, while it must also be remembered that imbeciles of adult age will torture and even kill, given the opportunity, little children as well as animals.

It is an interesting point, and one of some importance, whether patients on recovery retain any remembrance of their insane condition and it has been the practice here to always question them on the point. It seems that the very large majority do, but a few whose mania has been of a very furious type with very rapid incessant speech or perpetual movement for those days during which they were at their worst, a very confused remembrance, extremely vague, only remains. On the other hand, as is well known in this country, in insanity following hemp drug excess, no recollection is ever present in recovery dating back to the commencement of the attack, and this is a most striking characteristic and one of great importance from a medico-legal point of view. Epileptic mania is also attended with loss of memory for that period.

It is said that hysterical insanity has the same characteristic, but as I have never met with such a disease nor have ever found anyone who could give me any details of this variety, I am unable to speak of it.

Cases of mania usually occur in those with a neurotic or insane inheritance, especially in these in early life, though they are by no means invariably so. A history of Phthisis on one side and insanity on the other is very frequent. The exciting causes are those common to other varieties of insanity, the potent factor in all being worry and anxiety, (especially if this is combined with ill-health and starvation,) such as grief, loss, trouble, family, domestic or pecuniary anxiety and shame in any of their varied forms acting on persons predisposed for their action by heredity. In such people it is often seen after child-birth, it may be an evolution from delirium from any cause and may result from a toxin Indian hemp, alcohol, lead, arsenic, datura or stramonium. It may replace or follow epilepsy and very rarely may follow some cerebral lesion causing hemiplegia and other paralysis and may be seen in cerebral tumour, though I do not think that it ever follows actually on head injury, the result of this

being of a different nature. Mania is certainly most common between the ages of 20 to 35 and is then seen in every form. Attacks may occur periodically throughout the life of some people, or mania and melancholia may alternate with health, a condition which is Kræpelin's argument for believing that these two diseases only form stages of one malady termed by him mania, depressive insanity. Of all cases of insanity, those of mania are the most likely to recur, and the more so, the greater the neurotic history of the individual. It is said to have been noticed rarely in children. Certainly in India one sees occasionally instances of most furious acute mania (not apparently toxic) in youth between 15 to 20 and in girls at the same age. Such cases usually recover completely after some six weeks, but they are of a severe type and are usually marked during that period by several relapses. The patient may seem almost cured for about a week or 10 days and then everything recurs *de novo* and this may happen again for a third time before the final recovery results.\* Lastly we have had most typical examples of acute mania in old white-haired men. Such cases recover after a short interval, but the period of comparative sanity, after having lasted for a month or six weeks, is nearly always followed by another attack, and, once started, this cycle seems to continue indefinitely while life lasts. Several of these I have watched for three or four years and no material improvement ever seems to be permanent; indeed, the intervals of sanity tend to become shorter. I regret that it seems impossible to me to lay down any clear line for forming a definite opinion as to the duration of any attack of mania, though roughly speaking, the more acute the disease, the more noisy, restless, insubordinate and destructive the patient, the more likely is he or she to make a complete and rapid recovery.

The cases in which fits of silent brooding fury is a marked characteristic rarely are cured. All cases ought to, for their own sakes, undergo a period of probation of one or two months, after all the acute symptoms have subsided before an opinion is given as to their absolute sanity, and no one should be regarded as cured, however quiet and possessed he may apparently seem, if he retains any delusive idea of his relatives and friends being "against him" (due care being taken to ensure, however, that his statements on

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\* Such people often appropriate anything and everything they see and may be charged with stealing.

this point unlikely as they may seem are not really true), or if he fails to realize that he has been insane and the justice of his detention, and, above all, no educated man ought to be pronounced cured who cannot and will not write sanely; it is a curious fact and one well worth remembering that a man may exhibit few symptoms of his disease, and yet, if left alone with papers, pens and ink, will cover these with absurd letters full of delusions or well drawn hieroglyphics.

It is hardly necessary in this country, where G. P. I. is unknown, to warn the student that some few cases at the onset of the disease show a maniacal condition, but the fixity of the pupils to light, the slurring speech and history of convulsions, the weakening of the memory and the general physical condition serve easily to differentiate the malady.

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## CHAPTER XI.

### CHRONIC MANIA.

While a certain number of cases of acute mania recover (perhaps 20 per cent.), and some few die; unfortunately the remainder, the large majority, lapse into a chronic condition for which the term of chronic mania is applicable; they lose the intensely exalted emotional condition, but the acts, speech and behaviour of mania persist, and there is always a certain amount, great or small, of weak-mindedness.

Such cases form the larger number of the inmates of certainly all Indian asylums. These are often good harmless workers who, under supervision, perform most of the ordinary duties of the institution, and without whose presence a vastly multiplied staff of attendants and servants would be necessary. In the asylum such work in the garden, weave and make up the clothing and matting, and according to their caste, cook, wash and attend to the conservancy and a hundred and one other duties essential to its existence, and as a chronic mania rarely recovers, continue to do so all the remainder of their lives or until by progressive weak-mindedness they become so harmless that they can be removed by friends or

relatives. At the same time it must not necessarily be concluded that because a maniac, even at the expiration of a year or longer, shows no signs of improvement that his case is a hopeless one. A few, after repeated recurrences, recover even after two or three years, and women sometimes do so in a surprising manner at the menopause—in others, the acute symptoms gradually and slowly lessen, and sanity supervenes or an attack of pneumonia or a carbuncle or some other acute disease happens, and as though by the shock of this, the patient arises from his sick bed sane. But in those in which the term chronic is most properly applied, the acute symptoms lessen, while instead of making a gradual recovery, the patient is left literally in a chronic condition, he can be induced to labour, is not dangerous or so restless as before, has sufficient control over his attention to heed what is said to him, but he has some peculiarity or several. In the first place, he is careless of his appearance, indifferent to conventions of his race, caste and standing and unlike in looks, speech and acts to sane men, and he is incapable of correct judgment and reasoning. His speech is either wandering or silly, or incoherent, or else he is incessantly jabbering, talking and declaiming frequently on the subject of some delusion. One man here, though an excellent cook, daily doing 9 hours of good work that no paid servant could excel or equal, is always at the sight of a newcomer chattering on the subject of some Law Suit and of his intention to reopen his case; another, though he works well in the garden, declares that he is the Mahdi, dresses himself according to his ideas of that personage, and grumbles constantly at the difficulties in the way of attaining his purpose.

The former man too is careless of his dress, no longer washes himself unless obliged to do so, allows his hair to hang loosely round his head in striking opposition to what a man of his good caste would appear when sane and of his own former habits. A delusion is extremely frequent and usually it is on this subject that the patient chatters. Hallucinations also frequently continue. One man constantly complains that he daily hears his enemy and sees his enemy—a Dhoby on a tree abusing him—they however form a strong contrast to cases of true paranoia, as apart from their appearance and habit, their delusions are not systematized and worked out, they are not reticent or suspicious on the subject of their being always ready to detail them to any listeners and, unlike these latter, from the first there are often hallucinations.



Others indifferent (these are frequently women) to whether they have a listener or not, talk continuously and incoherently on subjects that it is difficult or impossible to comprehend. In yet others the period of relative calm is broken by fits of passion without apparent cause; while others nurse their delusions in placid cheerful contentment like the old man here who, content in the idea that he keeps "2-dozen" hounds somewhere near, never asks to see them and spends his day spinning like a woman. Many have some peculiarity of dress; one will make himself an enormous turban and wear several pairs of trousers and strut about the whole day in placid thought, while another does the same singing some disconnected words, with a blanket, and that only tied around his middle. For it is not all that will occupy themselves, and those that do so, will be noticed do it only as long as the fancy takes them. Women especially will tie rags round their ankles, strings around their toes, in obedience to some delusion, and in the same way men will make themselves crowns of paper and flowers. Some few are in a constant brooding rage, though this is more common as a sequel to melancholia, and there are yet others who, retaining the movements, habits and dress of a maniac, refuse to speak; we have one here who has not done so for 15 years. Such will often write their requests and in the same manner explain the hallucination, usually a supposed order from some mashid or fakir that obliges them to act in this manner.

Gradually, sooner or later, most of these cases end in dementia, that is to say, they become progressively more and more weak-minded, losing all memory, volition and intellect. Every chronic maniac shows a certain amount, even though it may be but slight, of this defect; it is, therefore, obvious that as these cases follow every variety of mania, and that in a large asylum patients of any and every duration of malady are to be seen; there will be found there every conjunction of possible degree of chronic mania with less or more of loss of intellect and volition, and that the same patient will vary slightly and progressively according to the length of time his malady has existed. The change is always gradual. A man becomes less and less assertive and more and more amenable and apathetic until at last completely demented, he drifts into an automaton capable of being ordered about by anybody, adorned it may be in gaudy finery, forgetful of his caste, eating from and with anybody and neglecting all cleanliness and becoming ultimately a mindless vegetable content to sit blinking in the sun, asking for

nothing, taking food of any kind when given him, passing his excreta under him and rarely even speaking of his own initiative.

This, however, is the final stage, and as a converse, a chattering foolish, cheerful dishevelled maniac, with some curious habit or delusion of several years standing, may be seen with fairly good memory and a marked will of his own and clean as to his excreta and still with some remnant of caste prejudices. The speech in almost all is "foolish;" it is impossible to carry on any sensible or sustained conversation with them; they either rapidly wander off the point or answer any question with a foolish, silly remark or commence about their dominant delusion or else recommence rapidly the incessant flow of words, the "Logorrhœa" which is characteristic of so many and which only an impressive question or stimulus has caused temporarily to cease. Some patients will pass their days in one limited occupation, plaiting straw which they never finish, and groping about picking up small articles collecting rubbish, polishing stones, etc., etc. The close connection of emotion and instincts is well shown in the facts that these persist or are natural until almost the very end—a man deaf to all else, will without obvious reason; while chatting aimlessly and foolishly, break into childish rage and ill-temper or more rarely into a flood of tears. Memory for past events, if speech is only sensible enough to prove it, persists extremely late—the majority never lose it, but that for recent events becomes, with advancing dementia, gradually more and more feeble and eventually is lost altogether.

Many of these cases are very destructive; they tear in pieces or disfigure any clothing given them, and habitually go in rags, while others refuse to wear any clothing whatsoever, and especially is this seen in women, some of whom will, by preference, sit huddled up in straw with their own clothing lying beside them.

Though the striking symptoms of chronic mania and the relative amount of intelligence and reasoning power of necessity so varies, there are certain characteristics common to them all and which "en passant" form a sufficient explanation for their detention in an asylum. Even though the very so-called emotional condition and the rapid flow of ideas and constant movement and restlessness met with in the acute condition may have practically subsided, they are (1) unable to take up their former life or to go back to their old occupations, the majority having no wish to do so.

(2). All their social feelings are perverted, they are incapable of fulfilling the duties of head of the household or of husband, wife, or father or mother; frequently they have lost all regard for, even if they have not an actual dislike for, their nearest connections, and one and all "go their own way;" they are regardless of the usual restrictions and requirements of social convention and, what is more, resent all interference and advice.

(3). They can, in no way, be induced to fulfil any of the above functions by any exhortation by any idea of responsibility or threat of punishment.

(4). They are all "peculiar" and most of them have habits rendering it difficult for them to be retained as members of a household—for example, some of them will go naked and others have no regard for decency, will use any place as a latrine; another will collect rubbish—one such man here in addition to being given to foolish meaningless chatter and to disordered dress goes about eternally asking for "news" and collects all the morsels of paper he can find, putting these into a bag he carries about with him, making a bundle daily increasing in size up to enormous proportions, and which, if he moves five yards from one place to another, he carries with him, and the large majority are noisy, destructive, "troublesome" in every sense of the word, selfish, with no regard for anyone but themselves, unteachable and untidy or unclean.

(5). They have usually some delusion which even, if fleeting and not systematized, is of a character to render them an annoyance or trouble to others.

(6). In all there is more or less mental weakness.

(7). Not invariably, but very common, is some physical change, the hair becomes prematurely gray—some have hæmatoma of one or both ears—skin eruptions are frequent, they bear marks of injuries self-inflicted or received as the result of quarrels, and these with their disordered or peculiar dress and habit cause them to assume an appearance which is fairly characteristic of the class they belong to.

The peculiarities of each are best understood if it is possible to obtain their clinical history, and it will then be seen that each is the result of a previous attack of acute mania from which some of the more obtrusive and prominent symptoms have subsided and left that which now remains with a general impairment of self-control and judgment and reasoning which, as life goes on after a longer or shorter stationary period, ends in complete dementia

Occasionally, the most marked feature in the condition is a delusion which obtains so much prominence as to liken the case to one of chronic delusional insanity. There is, however, always the history of the onset and the presence of a certain amount of weak-mindedness, the frequency from the first of hallucinations; and the absence of the typical condition of suspicion and the peculiar habits which usually accompany it, are usually sufficient to make the diagnosis an easy one.

Usually, cases of chronic mania continue in this condition for many years, the physical health is fair, appetite is good, as is also their power of assimilation, and thus life takes on an easy tenor which never seems to change, though in some it is broken, even after a long interval, by a recurrence of the more maniacal symptoms, and sometimes this in its turn is followed by a change in the patient's behaviour and habits, but hardly ever by a return to sanity, for this disease may be looked upon as incurable, though at the same time it must be owned that it is difficult or impossible to say when a subacute maniacal state has passed into the hopeless chronic one either in intensity or duration, or in other words one cannot say after the lapse of such and such a time from the commencement of insanity or with the onset of such and such symptoms the sufferer is incurably and chronically insane. Perhaps, one may fairly judge that a maniacal condition, particularly if the more exalted state has lessened and signs of weak-mindedness show themselves after two years duration, is practically hopeless—always remembering that females at the menopause occasionally give some wonderful examples of unexpected and long-retarded recoveries.

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## CHAPTER XII.

### MELANCHOLIA.

Is that form of mental disease in which the patient suffers from an unreasonable mental depression. A form of emotional insanity in which there is an unreasonable feeling of misery. An intense feeling of mental pain out of all proportion to its cause, or persisting when this has been removed. Mental pain from brain disease. Shown by the appearance, gestures, speech and conduct and frequently accompanied by delusions.

Any one may be depressed and sad or suffer mental pain or be melancholy "after great trouble or loss; but an insane melancholic either has no cause for his feeling so, or his grief and sadness is out of all proportion to the cause, or the cause that he gives is one that does not exist except in his own imagination.

Melancholia is usually of gradual onset and very rarely indeed arises suddenly.

It is necessarily modified by the circumstances of the patient to some extent, a man of good culture and training being able to control the signs of mental pain which an ordinary villager sees no reason for restraining. All cases are associated with some defect of nutrition.

It cannot be too strongly insisted on that a medical man called in for an opinion must take every reasonable precaution to ensure that the cause assigned by a patient for his depression does not really exist—that he really has not lost all his worldly possessions, and been neglected and cast out by his children, or that some lingering disease really does not affect his abdominal organs. With the man suffering from delusional melancholia, who will explain his weeping and misery as due to the fact that he has lately fallen down from heaven and cannot remember the way back; such difficulty does not exist, but the simple varieties are sometimes open at first to doubt which can generally be dissipated on a careful consideration of their history, the relations of the cause assigned to the extent of the depression and misery exhibited by the individual in relation to his habits and training.

Usually melancholia attacks people predisposed by their hereditary history and by the presence of a nervous system or small vitality with unduly feeble nerve action; people easily fatigued and exhausted with small reserve of strength; its exciting cause being any unusual and unexpected drain upon their energy and vitality, such usually taking the form of some sorrow, anxiety, loss of money, prestige, family troubles and death. Nothing so frequently will be found to be so associated with its occurrence in this country as this latter; the death of children and many members of the family, the shock and the disgrace of the wife's infidelity. The same explanation applies to its occurrence at puberty, and during pregnancy and after child-birth, suckling and at the climacteric, that is to say, that it always follows some form of exhaustion either from bodily disease or the still more potent one, of physical or mental prolonged strain. Anything indeed

that causes naturally grief, sorrow and anxiety in the predisposed people being most effectual, predisposing causes always being exhausting diseases, want of fresh air, excesses and exhaustion of over-study and excessive exertion, this being exaggerated and persistent as melancholia when it then assumes a form out of all proportion to its cause or persisting unduly long after all the causes have passed away or should have been forgotten by a normal individual. It may be difficult to draw a line between extreme melancholy and insanity but such is always possible.

The ordinary sane individual may be in a state of mental pain and suffering, but he is still able to reason sensibly, he does not lose his self-control, he does not necessarily wish to commit suicide, and he naturally continues his ordinary employment and occupation by which he gains his own living and that of others; and though he may not, on account of his grief, take so much interest in the ordinary affairs of every-day life around him, his interest in the same is not absolutely abolished.

The insane man, on the other hand, has a mental pain and sense of apprehension; out of all proportion to what has happened, he loses his self-control, will probably have some insane delusions, may want to commit suicide and in particular is absolutely incapable of following his former employment, and loses entirely his interest in everything going on around him.

Melancholia is, as a rule, one of the easiest forms of insanity to assure oneself of. For the patient, though he may very probably assign a cause for his illness that does not exist, will speak fairly sensibly and describe his own sufferings accurately, and is sure, otherwise on the point that he is very ill as opposed to the maniac or paranoisc, who will scorn the idea that there is anything wrong with him. This disease is strongly hereditary, I am even prepared to say that it cannot arise absolutely *de novo* in any individual under the most extreme causes likely to execute it; certainly no such case has even come under my notice, while everybody must be able to recall instances of individuals bravely bearing their troubles amidst almost unbroken adversity to their lives' end, yet never being changed apparently mentally.

Many cases of mania are preceded by a variable period of depression, and true melancholia may be replaced by a period of maniacal excitement. For this reason some authorities would have it that melancholia is only a stage of one disease which, if fully developed, and if recovery does not intervene, may pass on to

mania, but the types of it vary, and some of the more profound varieties are so lasting, and so many cases end in dementia without any attack of mania being seen, that this opinion seems to the writer more than doubtful.

It must always be remembered that melancholia may be seen in one of the stages or as one of the varieties of G. P. I. Many vary in degree from a condition of mild, though unwarranted depression to an active form in which everything betokens the depth of despair of the individual, and its most prominent symptoms may be (1) an all-absorbing desire for suicide, or (2) a delusion crystallized as it were out of the feeling of misery and appropriated as its cause, or (3) the condition of melancholic stupor or melancholia attonita, which latter is so peculiar and characteristic as to need separate description. Its names and varieties are endless, but putting aside the cases in which it is a preliminary to mania or is one of the stages of G. P. I., we may have acute or chronic —

Simple melancholia.

Melancholia with delusion and hypochondriacal melancholia.

Active (excited or motor) melancholia.

Most frequently an acute variety though not always so.

Melancholia attonita.

Suicidal melancholia, resistive or obstinate, though often differentiated, do not really form separate types.

The names of these varieties partially explain themselves, but in all cases there is intense mental pain, the patient feels miserable—looks so.

The facies is said often to be characteristic, the face itself elongated from the falling down of the lower jaw, the forehead showing several transverse *wrinkles* on its upper part and vertical ones below at the junction of the nose and forehead, the eyebrows drawn up at the inner end, the outer being drawn down, the corner of the mouth also being markedly depressed.

The attitude expresses the same prevailing idea. The body is always bent, the head bowed and back bent, as are also the lower limbs, while even the hand has a nerveless attitude. With the thumb in a line with the fingers never opposed to them. There is marked rigidity of the proximal joints; a fine tremor of the fingers is sometimes noticeable. Either the patient is slow, self-absorbed, sitting down alone and rarely moving, or he is constantly full of

gestures of intense grief ; he has always the eyes full of tears or is actually weeping ; he wrings his hands, clasps them, sighs, groans or bows his head back and forward for an indefinite number of times, or sits clasping it with his hands or roams ceaselessly about, huddled in a blanket, moaning and complaining, breaking out into fresh complaints at the sight of a visitor, frequently, instead of complaining, emitting one monotonous ejaculation of God if a European, Ari Bap if a native, slowly and without variation.

Nothing will induce him to occupy himself. He will roam about weeping and mourning, or sit in one corner dejected and silent—taking no notice of anything around him, but unlike a dement absorbed in his own thoughts. All the symptoms are aggravated at night, especially towards the early hours of the morning at about 2 or 3, at which time in those predisposed to suicide, there is the greatest danger. Many, indeed a majority of melancholics, have a tendency to suicide, and if fully determined to do so, nothing will prevent them short of unceasing surveillance. The danger must never be forgotten, and if it is desired to prevent it once the suspicion is aroused, such a patient must never for one instant or second, night or day, sleeping or waking, be left alone. Curiously enough, in such people each has his own particular form of taking his own life ; a man who attempts to hang himself will pass untouched knives, pistols, or water, and yet if left alone, will unravel the threads of his sleeping mat and hang himself on a tree branch to avail himself, of which perhaps it is necessary for him to kneel down. Also such patients, if they see an opportunity, will quite suddenly as though in a flash take advantage of it, and their suddenness and rapidity of action is surprising, especially in contrast to the former difficulty of arousing them.

Many melancholics show considerable obstinacy ; will object to every suggestion ; do nothing they are asked. In those who with every outward appearance of melancholia resist every movement and in whom there is passive (?) opposition, the conditions correspond to that described by many writers as catatonia. Sleep is always defective, all melancholics show a repugnance to taking food ; in many advanced cases they refuse it utterly, and cases will be seen where for months or even several years all nourishment has to be given by a tube.

If they speak at all (many do not), it is noteworthy that this is one of these varieties of insanity in which the speech *per se* is absolutely coherent ; the patient will answer in a depressed tone,



often in a semi-whisper indicative of great suffering and misery, but will give a perfectly connected, coherent, though emotional explanation, however false, of the sufferings and of the cause of his misery. Their memory is good even for recent events. In advanced cases, however, it is frequent for them to refrain entirely from speaking, and nothing is more striking than the motionless man or woman, always maintaining the same attitude, leaning forward with eyes half closed, with dirty, greasy, often clammy skin, unkempt or matted hair, regardless of all around, perhaps passively resisting all movement and irresponsible to all stimuli. The face covered with flies which they make no attempt to remove (a picture, however, presented alike by melancholia and catatonic stupor).

All these cases, just as they are indifferent to all around and to their own personal cleanliness and tidiness, if in a still advanced stage, become absolutely filthy and will pass all their excreta under them like an infant.

There is in all a marked failure of nutrition ; the skin becomes earthy, sallow and yellow, that of the face often being peculiarly greasy and clammy, the extremities blue and cold, the circulation defective, the breath foul and fœtid, the tongue coated, appetite may be said practically to be non-existent, and many, as already said, will touch nothing in the way of food. From the tendency to maintain one attitude or to refrain from movement that is such a marked symptom, it is not at all uncommon, in cases of prolonged duration, to find a certain amount of rigid flexion of the legs or the thighs which cannot be overcome except by the use of long-continued massage and forced movements daily persisted in for weeks.

This rigid flexion is especially frequent in cases of resistive and stuporose melancholia in whom the condition described by Kræpelin as psychomotor retardation is evident, where there seems to be a resistance or impediment to the exertion of the will varying from slowly emitted, half audible speech, slow retarded movement to actual immobility—here seen in its highest development. However slight the melancholia, there will always be noticed a certain rigidity of the neck and shoulder muscles, a rigidity of flexion (Stoddart).

Constipation is almost always present and sleeplessness is common to all ; a patient may remain weeks without sleeping an hour.

In this country for a reason impossible to explain, it is a frequent thing to see such patients cast off all clothing and regardless of decency, sit or lie absolutely naked, or at the utmost covered by a blanket, and for this reason and that, all show an incapacity or unwillingness to react to any cutaneous stimulation however painful, it is probable that there is a certain amount of anæsthesia.

As regards the several varieties of melancholia—as is well known Kræpelin would apparently restrict this term to these cases occurring at the period of involution and would class all others as types of mania, depressive insanity, and his teaching is now followed by many. (These views are excellently given in Defendorf's Clinical Psychiatry.)

This may be so, but at any rate in India any variety of melancholia without any periods of mania may be seen, and many cases pass on unaltered to end in dementia, so that the writer prefers to follow the usual grouping of English scientists.

Simple melancholia explains itself; it is the mildest variety and may often pass on into either of the others.

In the form well described as active motor or excited melancholia, the patients, instead of sitting or lying, walk ceaselessly up and down, wringing their hands, clutching their hair or their foreheads, moaning, crying or weeping, or ceaselessly uttering one monotonous exclamation, continuing for days or nights to show the grief that absorbs them in every form of outward manifestation; nothing will induce them to sleep, eat or rest.

Such usually in this country cast off all clothing, though in my experience they rarely commit suicide.

Contrary to what is found in mania, the blood pressure is raised in all forms of melancholia (the pulse full and slow), falling to the normal on recovery, and also rising through the day and becoming highest in the early morning, coincident with which the depression is then most intense and the danger of suicide greatest; but this form of melancholia is an exception and the blood pressure is lowered, the pulse small and rapid, and for this reason it has been urged that this disease is really only a form of mania. (Craig, Psychological Medicine, p. 96.)

In this as in all forms of melancholia it is impossible to reason with the patient; he cannot reason justly and is unassailable by any argument, and when he can be induced as in the simple variety to urge his own views, it will always be found that his

reasoning is feeble, faulty, and that he will wander round and round a point of complaint without ever adducing a valid reason. Hallucinations of the senses in simple or acute melancholia are very rare and in the agitated form it is not possible usually to get the patient sufficiently aroused to obtain any description of them. Indeed, it may be broadly stated that a state of simple depression, at any rate, with hallucination in a young person, is nearly always one of commencing dementia præcox and not true melancholia.

On the other hand, delusions as to the cause of their misery are very common, and when very prominent, give rise to the form described as delusional melancholia—it must, however, be remembered that delusions in this disease arise from the mental pain as an explanation of it—they do not precede it as in paranoia.

In Europe and especially in England (also in the United States apparently), these frequently take the form of some particular crime they have committed (usual of a trivial nature), and for which they are eternally damned and rightly punished. Hence, the popular idea of religious melancholia. Like all insanes, this species is pre-eminently egotistic; his sin and wretchedness, his unworthiness are more than any one shows and can never—never be relieved, etc. Such feelings being foreign to the natives of the country are never seen here; in these people it is usually some family or material loss or injury, that they are alone, their family is starving, that all have combined to oppress them, that their children are dead, etc. (and like all delusions no ocular proof of the well-being and good health of those they believe in want and starving will ever convince them). Some few declare that they have insulted the tomb of some pir or spoken badly of a fakir and are wasting away and suffering daily misery in consequence.

In others both here and in Europe the delusions are as to some bodily illness or injury, and these are the cases described by some as hypochondriacal melancholia; that they cannot have an action of the bowels, commonest in natives of advanced age, that they have a mortal abdominal disease (it is curiously rare for the delusion to be of any other part than the abdomen), that they are doomed to die, that they have an incurable disease, etc. In some the idea is of an injury, and frequently this is of an absurd character. One man here for two years has declared that a bullock cart has gone over his body, and that he must in consequence die at once in torture. Such ideas are endless in their variety as in their iteration and

the prognosis is bad, the disease then being of long duration and often not recovered from.

In the large majority, especially in the young, and if treatment is commenced early, the disease soon passes away completely, though it must not be forgotten that of all the forms of insanity, this is the one most likely to recur or to be followed by some other form of mental disease after even a very prolonged interval. The mildest cases of simple melancholia, if the patient is quickly removed from his surroundings and friends, and relatives, is put into a novel entourage, preferably that of an asylum, is continuously fed with large quantities of nourishing food, usually quickly recover and may do so completely; even in severe cases; if these are removed from home and relatives and are forced to take some form of exercise or occupation (the most difficult thing to induce them to do), a recovery may in the majority be expected; nor is the strongest possible hereditary taint necessarily a bar to such an expectation. With natives it is of course difficult to induce the relatives to see the necessity for any treatment at all, and especially to the removal from home which is so absolutely essential; and if this be not possible, the provision of exercise and regular feeding and nursing is out of the question; such, however, is absolutely necessary—sometimes the institution of regular forced feeding—large quantities of liquid nourishment being given every two hours if necessary by nasal tube with persistent massage is practically the only treatment possible, and under this even, if regularly carried out, the constipation vanishes, the patient begins to sleep, the general nutrition improves, and with it his or her mental condition gradually changes to the normal. Drugs and hypnotics seem absolutely valueless, though in those cases with great restlessness large doses of morphia by the mouth 30 minims of the Liquor every two hours, until two drachms have been taken, has occasionally seemed of service. As often it is useless. With such enormous doses obviously great care and attention should be given—the drug must be stopped on the first symptoms of sleep coming on—as a rule, it has no obvious effect whatever in that way.

Some few cases, instead of improving under treatment, become more and more bodily feeble; they seem as though “worn out” or to have their vitality crushed out by the all-absorbing grief which renders them immobile and silent and they finally die. This termination is not unknown in young women, though in this country it

is perhaps as frequent in men of advanced age—in such, melancholia supervening for the first time is very apt to prove fatal.

The cases sometimes described of comparatively rapid increasing melancholia, often following on some great grief or trouble, culminating in death, are those from which probably the idea of death of a “broken heart” has arisen.

They are not so very infrequent, but in this country are as often seen in men as in young women, but then the objection held here to placing women under treatment probably account for this. Many more in all probability die unseen.

The normal duration of melancholia very much varies. A simple case may recover in a few weeks and a more acute severe form may last months to two years. A considerable number, too, instead of terminating in death or recovery, may continue without variation or with perhaps some diminution in intensity for years or indefinitely, and the case passes then into what can only be described as a chronic condition. This, however, has nothing but its duration to distinguish it from any other, though in a few cases the marked manifestations of grief and depression become blunted, while the delusions produced by them remain as the main symptom. Here it may be remarked that it is sometimes stated that the main condition in melancholia is one of fear, of apprehensive depression. There is certainly a belief in impending calamity, often an all-pervading sense of evil, of everything being wrong, but it is an open question whether this can be rightly called fear.

This, however, is not the commonest affection following a great shock, especially if of a sudden nature; when insanity then supervenes, it is very commonly acute delirious mania, or even acute dementia (energetic stupor) or a form of exhaustion psychosis.

It is obvious that a man, a melancholic, who without cause feels himself to be ill and dejected, whose whole thoughts are occupied by his misery, still more so if he has evolved some delusionary explanation of this of a fear-inspiring nature, however apparently coherent his speech may be as that of these men usually is, is incapable of really correctly judging and reasoning and certainly of correct conduct; he shows that in every case, by losing his interest in the details of life and in his change of habits, if he is an intellectual man, he cannot read—his thought is no longer clear; in all classes there is a want of vigour in

the representation of ideas, while the predominance of feelings of anxiety and of painful subjective sensation and ideas becomes more and more marked. By giving himself up to introspection he becomes irritable over trifles, the ordinary play and consideration of his ideas becomes hampered, and his power of attention to anything but his misery weakened; all his mental operations are reduced in range and activity and only performed with effort; his will seems restricted: a natural consequence of the restriction of his feelings to the one subject, and, as Bevan Lewis points out, there is with a rise in subjective feelings a fall in the objective. His egotism becomes more and more prominent with a failure in any true appreciation of the environment.

It is obviously impossible to have one faculty (*sic*) of the mind so affected as in these cases without the entire intelligence being also impaired. A melancholic is always unreasonable in every sense of the word; he cannot see that his misery is causeless, that others are just as bad as himself or equally unfortunate, and he resists and fails to appreciate every effort made for his well-being; there is far greater impairment in these cases of judgment, reasoning and power of self-control even than is seen in the worst cases of mania and so, though one speaks of cases recovering completely, it is therefore not surprising, even after apparent recovery when the actual manifestations of grief and misery have subsided, to find very frequently, more so perhaps than in any other affection of mind, a certain amount of intellectual defect has resulted—only perhaps appreciable by those who knew what the patient was before his illness, by those immediately around him, his family, wife or husband.

Still more frequent is what can only be described as a certain blunting of the moral sense. The patient after "recovery" is egotistic, selfish, incapable of application and is irritable over trifles that formerly would not have affected him. Such a condition is still more common in those cases where most of the active symptoms have subsided, and yet one cannot but say that the patient is still insane. He may have recovered sufficiently to eat and sleep well; he can be got to do a little work under persuasion or compulsion, and will move about and talk when addressed with fairly good sense, but he is absolutely a changed man; he is selfish, moody, morose, resentful of fancied slights and difficult to manage, and is above all unable to control his temper. Such patients, and many well-marked examples of this

kind, are seen among the criminal insanes of this country (I append one excellent example) and are most dangerous; some trivial act, some petty provocation, a fancied affront, and they will fly into a violent rage and enter into a passion that nothing can control, in which they will tear, destroy, or murder. Such cases of half-recovered chronic melancholia,—I know no other name for them—form a large proportion of the criminal lunatics (guilty of homicide) seen in India; and no man of this character ought to be allowed out of the asylum; they have no delusions, will speak perfectly sensibly, keep themselves clean and tidy, but seem to have always an idea of personal injury; they are always lowering, morose, difficult to please, and above all liable to fits of uncontrollable diabolical rage from trivial occurrences which it is difficult to foresee and impossible to prevent. There is of course every degree in such cases; many have come under my notice, but no one has ever shown a recovery.

A certain number of ordinary chronic melancholics, on the other hand, continue for many years in the condition of mild misery, and refusal to occupy themselves, into which they have subsided; they are difficult to tend and need constantly being supervised, to see that they are fed and clothed, but otherwise they are not troublesome nor are they dangerous. Such are often carried off by intercurrent diseases, phthisis or chronic dysentery, but on the other hand after a period, the duration of which it is impossible to forecast, they pass into a condition of dementia from which of course they never recover.

These are almost always cases in which the primary disease was in itself of long duration. It used to be said that a certain number of young adolescents attacked with melancholia, especially if they had been addicted to masturbation after about a year, although they began to gain flesh instead of recovering, exhibited a gradual loss of intelligence, a weakening of will-power and of memory which more or less rapidly advanced to complete dementia; it is now known that there are really cases of dementia præcox. It will always be noticed in such cases that from the onset, even where the state of depression was mild, that there were marked hallucinations of the senses and often some silly delusions neither of which are seen in ordinary melancholia.

On the other hand, experience tends to prove that any case of insanity in which from the first the patient gives way to masturbation, very rarely is recovered from.

Some very rare cases of chronic melancholia are seen usually in women at the menopause, when, after even many years, a sudden change sets in and a fair amount of recovery follows, sufficient indeed to warrant their being returned with safety and comfort to their own friends. Finally, rarest of all, in some few, after many years, a chronic melancholic may suddenly develop all the symptoms of an attack of subacute mania which may continue for a long period or be indeed absolutely substituted for his former condition.

It is presumable that some forms of melancholia may be mistaken for dementia, the diagnosis resting chiefly on the obstinacy, resistance and evidences of will-power afforded by the former. Like some melancholics, a dement may be motionless all day without eating or speaking, passing everything under him and paying no attention to his environment, but he sleeps well ; and though he may not ask for food, will eat it greedily when given to him ; he obeys any order of any person if he understands it ; he will answer, though foolishly, when addressed, though giving every evidence of having no memory whatever for any recent events ; whereas, on the other hand, a melancholic's speech, when it can be obtained, is apparently sensible and to the point, but then he will do nothing he is told, resist every movement, will not eat and cannot sleep, and his marked failure of nutrition, his greasy, earthy, pallid skin contrasts forcibly with the dement who, if well attended to, is often in very good condition.

It may be a question of distinguishing between a mere hypochondriac and a melancholic : the hypochondriac, unlike the latter, though full of his ailments and miseries always hopes to recover and welcomes his doctor as his saviour and protector. The melancholic, on the other hand, is certain that nothing can ever cure him, that he is bound to die, and that all remedies and advice must be of necessity useless and unavailing.

As regards prognosis, the hope of recovery is said to be better when the disease attacks a young person and is very gradual in onset and when it follows some obvious and reasonable cause, while the presence of fixed delusions or hallucinations (the latter, however, are not at all common in melancholia) renders the outlook graver. The active motor variety, with plucking out of hair, picking at the skin, dirty habits and constant vociferation, is always very prolonged in duration and less likely to make a complete recovery. Old people of feeble health with marked arterial degeneration, in whom there is some fixed delusion of visceral disease, almost



always die, while at any age and in any sex rapid emaciation and persistent and absolute refusal of food are extremely unfavourable indications.

We may say therefore that melancholia, if simple and in the young, is usually recovered from, though a relapse in after-life is very frequent. It may be followed by death in the young when the symptoms steadily increase coincidentally with a rapid failure in general nutrition.

It may pass into another form of insanity or into melancholic stupor.

It may without changing its type become chronic or may do so after subsidence of the more obvious signs of depression.

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## CHAPTER XIII.

### STUPOR.

As elsewhere, there is a condition of insanity not at all infrequent in Indian asylums of a very remarkable and distinctive character. A man will be for many months, even one or two years, practically in one position, motionless, silent, passing his excreta under him, making no reaction to any form of sensory stimulation. You may pinch him, strike him, shout to him, use any form of cutaneous irritation, he will not move or speak, or, indeed, show any sign of perceiving the same. He will not ask for food, and in the most marked cases, if the same be placed beside him, he will not touch it, and it will be found that to keep him from actual starvation, it is necessary to forcibly put the food into his mouth, when in some cases he chews and swallows it. But if, as it often happens, he will not even do that, it is necessary to feed him by a nasal tube, and in such a case this may have to be repeated daily for many months even (in one case here for 19).

These cases are usually described as melancholic stupor (*melancholia attonita*, occasionally *psychocoma*); we had a remarkable series of such here in 1900-01, see *Indian Medical Gazette* of October, 1902, but it is now thought that many similar ones, especially those in which the condition of passive resistance is replaced by one of active opposition, or where there is often *flexibilitas cerea* and no special rigidity of the proximal joints and trunk muscles that these are really cases of stupor occurring

in katatonia. The distinction is largely technical, and the various examples are, with only great difficulty, distinguishable from one another.

Other cases closely resembling these superficially are really those of so-called anergic stupor (acute dementia). In a few cases, if the stuporose state, following the exhaustion of an attack of acute mania and preceding recovery be severe, the condition may resemble that of true stupor: a differential diagnosis of these four diseases is appended. In this country, of course, the difficulty of distinguishing between each is immensely increased as no previous history whatever is obtainable, and you only see the patient when he is brought to you silent and motionless; it is, however, not a matter of very great importance, as if such cases do not, as sometimes happens, die of tuberculosis, disease of the lungs and chronic diarrhoea; they almost always recover ultimately; at least that is the experience here; there may be a little stupidity and dullness left, but some seem to recover absolutely. The disease is best described by giving examples of typical cases, and four are given here of those referred to above that occurred during 1901-02.

The first is one probably of melancholic stupor and is that of an unknown male admitted here on the 17th April 1901, aged apparently about 30. The man was arrested by the police, having been found wandering about cantonments, silently breaking flower pots and window panes; nothing was known of him or could be discovered; while under observation he quickly passed into a condition in which he was stated to have lain continually on his back, with the eyes closed, quite motionless except for some twitching of the facial muscles; he never spoke, asked for nothing, and ate only food placed in his hands, and latterly certainly passed all his excreta where he lay. These were all the facts received from him on his admission. From that time and up to the latter end of 1902 (with an exception of a few days in May 1901 when he only differed by eating a little of his own accord) this man had never altered in one single particular. Though not deformed, not paralysed, with no sign of physical disease, he lay and had lain ever since on his side half coiled up, absolutely motionless, never speaking, never moving, paying absolutely no attention to anything, flinching perhaps at some painful stimulus, but giving no other reaction. He was of a peculiarly yellow sallow complexion and the mucous membranes were slightly anæmic; the eyes were

tightly shut, and there was a distinct sense of resistance when they were forcibly opened, just as there was to any movement of the limbs or body, so that if it was desired to move him, he had to be dragged or carried; the urine and excreta were passed under him and he paid no attention to their presence, nor did he to the prolonged absence of food, which, however, he swallowed when placed in his mouth. The reflexes were all normal and his general bodily development as a result of regular forcible feeding still retained a good condition, and except for the complexion and colour and a certain amount of coldness and blueness of the hands and feet and the fixation of the face muscles in an expression of profound dejection, there was nothing else noteworthy.

It is obvious that his position and quietude were voluntary, for he gave a distinct passive resistance to anything done for him, and it is just as obvious that he felt. I have several times removed the blankets from his shoulders when a cold wind has been blowing and seen him, without a word, the next moment slowly raise his free hand, replace the covering and again become motionless; and if he were placed sitting up or leant against a wall, he slowly and silently regained his former position; but no noise, command, shout or any cutaneous stimulus, however painful, would cause him to open his eyes or give any voluntary proof of having perceived them or would induce him to speak. Towards the end of 1902 he gradually improved sufficiently to take food that was placed before him and to go and wash himself afterwards. The circulation coincidentally became less feeble; a large plaster was applied to the nape of the neck without much apparent benefit. From September he had begun to use the latrine, otherwise he remained stationary till about the middle of 1903, when he commenced to walk alone and to work a little under direction; his face lost the old fixed look of dejection and began to take on more expression, and from that time to the beginning of 1905 he remained the same, a quiet, intelligent worker, clean, decent, obedient, but always moving about with tightly compressed lips, never having spoken since admission. On one occasion, when pressed for an explanation, he wrote on paper "I shall die in a week;" though from time to time he made some sensible requests in writing. Suddenly in 1905 he made an escape from his attendant, but was apprehended the same evening, and shortly after that commenced to speak freely and intelligently and gradually became practically sane and was discharged cured early in 1907.

The second case is also probably one of melancholic stupor.

It is that of an unknown male found wandering in Bannu, and of whose antecedents, therefore, nothing is known ; he was admitted here on the 16th May 1901. From that day to the middle of 1902, during the whole of the twelve months this man's condition had never varied, nor had he ever moved or spoken. He was a medium-sized, wretched-looking man, of about 30, with an expression of intense misery, who used to stand, sit, or lie wherever he was placed with eyes shut ; the head usually bent, never speaking or moving, paying not the slightest attention to any form of cutaneous stimulation or to anything going on around him, asking or signing for nothing, and only eating when food was actually placed in his mouth (sometimes, however, he would do so if food was placed in his hand and then raised to his mouth). He passed urine and fæces under him just as he sat, and though it is obvious that he felt, never showed any discomfort from that condition. The eyes were usually shut and had a certain amount of secretion at the edges of the lids ; the general body surface was warm, though the feet were a trifle cold and blue ; the reflexes normal ; nor was there any evidence of paralysis or indeed any physical signs of disease. He remained as described, generally sitting with the head bent forward, the eyes shut, the legs under the thigh, the hands dropped to the sides, often leaning against the wall, always with the same expression of deep misery up to 1902, though by regular forcible feeding he was slightly fatter and better nourished than on admission.

About the middle of 1902, together with a marked improvement in the circulation, it was noticed that he began to move, to eat and to obey a little ; he gradually improved, began to walk about a little and was regularly drilled daily by another recovered lunatic, and he slowly changed into a quiet, timid, very anæmic, silent man. In February 1903 he suffered from a severe attack of colic and spoke for the first time, and by April was speaking fairly frequently, told his name a few months later, and gave a clear account of himself ; by the spring of 1904 he was extremely sensible though very timid, weak and retiring, and in time he was discharged sane. It appeared that he was a trans-frontier man and remembered wandering away from his home, though after that his recollection was hazy.

The next case presents an example of a modified form of stupor occasionally seen. It is that of an unknown male, of about

25, who was found wandering in Umballa, in March 1900. No other information is forthcoming but that he was sent for observation into jail, and his condition not improving, he was finally transferred to the asylum on 1st August 1900.

On admission to the asylum, he was noted as a small under-sized young man of poor physique, flat-chested, with a conical-shaped head, flattened laterally, but who presented no paralysis or deformity; the mucous membranes were anæmic, the complexion a pale yellow, and the skin, though natural in temperature, damp and greasy. The notes say that he sits or stands in one position, absolutely silently, speaking to no one and doing nothing, paying no attention to his evacuations, passing everything under him (he would ask for nothing, but would eat what food was given him). He can obviously understand and generally obeys any simple order, but nothing will induce him to speak, nor does he attempt to carry on a conversation by signs; he does not cry, or sing, or make any noise, but remains the whole day absolutely silent in a curiously fixed attitude as though staring at something with an expression denoting the greatest misery and dejection, occasionally turning the head and eyes when addressed loudly. There were no physical signs of disease on admission, though chronic diarrhœa commenced shortly after.

During the whole of 1900 he remained in this state, never speaking, occasionally however at intervals, replying by signs, remaining the whole day and night in one place and in one attitude, filthy in his habits and impossible to advise in any way. He was, however, not resistant and could be moved and attended to without trouble. In December he suddenly one day began to speak a little but unintelligibly, and very soon relapsed into his old condition, though somewhat less dejected in appearance. His general health then began to fail, and he died somewhat later of chronic diarrhœa.

The next case, one of katatonia, is that of K——, a Pathan. This man, when quite sane, shot his wife with a pistol and was in consequence tried by a *jirgah* who found that death was accidental, that the prisoner was handling the pistol when it suddenly exploded, the bullet striking his wife and killing her on the spot. He was then prosecuted for keeping a revolver without a license and sentenced on 19th February 1901 to six months' rigorous imprisonment. It was stated that at the commencement of this prosecution the man began to be morose and

"stupid," though he had been perfectly natural before, and that he remained morose, heavy and silent from the time of his entry into the jail, refusing to answer questions, and rapidly passing to the condition noted on his admission to the asylum on the 16th July 1900. No family history of insanity was obtainable.

When first seen here, he was noted as a well-made muscular young man of about 25, having a peculiarly depressed melancholic appearance and a sallow unhealthy complexion. Beyond a tendency to flat feet and a marked depression at the root of the nose, he presented no deformity or bodily peculiarity. There was no paralysis of any muscle, and the reflexes were all normal in reaction. He stood or sat or lay perfectly motionless and silent in any position in which he was placed at first; he occasionally answered in a whisper when loudly spoken to, but later on absolutely refused to speak, and only occasionally slowly raised the eyes at some loud order. Generally he would stand absolutely motionless and silent, the head bent, the eyes fixed on the ground, with a gummy exudation filling both conjunctival sacs; the forehead deeply wrinkled transversely and the features presenting a picture of absolute misery. He was to a certain extent cataleptic; the head, if placed in any position, would remain there; the hand could be placed in one posture and would there remain for an indefinite period, but at the same time it was only with the greatest difficulty he could be moved from one place to the other as he passively and silently resisted, so that, when pushed along, his limbs had the appearance as though of lead, being slowly dragged, though at other times he would move slowly aside to pass urine and fæces, and in this respect differed from most of these cases. Practically, during the whole time he asked for nothing, paid no attention to anything or anybody, and beyond occasional movements of the eyes showed not the slightest reaction to any form of stimulus, and would only eat food when this was actually placed in his mouth.

The skin was always warm, neither dry nor moist, but the mucous membranes were anæmic; the teeth were irregular and filthy; the tongue moist, white and furred, a view of it being only obtained with the greatest difficulty as he kept the teeth clenched and silently resisted any effort to open them.

There were no physical signs of disease in the thorax or abdomen. He was forcibly fed regularly, was kept warm and protected, but his condition never altered, and on the 20th August

of the same year, when handed over to his relatives who came to take him away, he was exactly the same, and the last I saw of him was a silent, motionless, huddled-up heap which they were preparing to lift up and carry away.

The last case is also one of Katatonic stupor; it is that of Q——, aged 35, who was admitted to the asylum on the 3rd July 1900. This man, having murdered his own mother, was confined in jail under Section 471 of the Criminal Procedure Code on 29th July 1897. There are no records of the circumstances under which he was deemed insane at that time, but during his confinement it was several times noted that beyond giving evasive replies his behaviour was quite natural. Towards the end of 1898, however, he developed a condition of melancholic stupor with occasional alternations of excitement; during the stupor his limbs are noted as presenting the condition of "*flexibilitas cerea*." Since February 1899, he had been almost uniformly in a state of stupor, silent except on rare occasions when he would ask for food or make some trifling complaint, and in that condition he was transferred here. He was then noted as a man of average height, of an unhealthy yellow complexion and clammy, greasy skin, without any paralysis or deformity, who spent the entire day sitting cross-legged on the ground in one fixed attitude, absolutely motionless and silent, the head a little bent forward, the eyes half open and full of glairy mucus, the lower lip so pendulous as to leave a cavity between it and the teeth which was always full of saliva. He would pay no attention to anything or to anybody and only, by vigorous efforts and loud speaking, could sometimes be made to answer, when he did so in a low faltering voice, generally sensibly. No delusion could be discovered. He was, however, clean in his habits as he would voluntarily rise and go to the latrine.

Sometimes he would take food offered to him, but more often he passively refused to eat and required forcible feeding.

He showed a certain amount of catalepsy, that is to say, that one hand and arm, if raised, retained that position until the other was raised when the first was slowly lowered.

He was fed regularly with a nasal tube whenever he refused food, was walked up and down the enclosure forcibly, was kept warmly clothed and protected, but his condition scarcely altered. One day he partially awoke and talked freely, but the next he again settled down to his previous condition. Signs of tubercu-

lous disease of the lungs began to appear, he emaciated rapidly and died of the disease on the 13th December of the same year.

It will be seen that all these cases present a condition in the main absolutely identical. As far as can be observed, they sleep though always in the same attitude, but with this exception, during the whole time, often extending to many months, the condition of a man with this affection or even this attitude never varies. Each sits or lies always in the same posture, coiled up, motionless and silent, the eyelids generally tightly closed, and usually showing some secretion at the edges, frequently with an excess of nasal mucus—the man never moving, speaking, or paying the slightest attention to anything going on around. The greatest noise or excitement, a push, a blow, an injury, the demands of nature, all fail to arouse him; he passes everything under him (some few rise and pass their excreta to one side); never asks for or searches for food, and though he will usually swallow when this is placed in his mouth, he would otherwise, even with ample nourishment placed in front of him, lie there regardless of it as far as can be seen, until he died of starvation. Nor is there under any circumstances any manifestation of emotion. Each though obviously well able to feel and with all the cutaneous and deep reflexes in perfectly normal condition seems otherwise insensitive to any stimulus of any nature and of any sense. One and all vary from a condition of passive to obstinate resistance to all endeavours to move or arouse them, each having to be dragged or carried to any place to which it is desired to move them; indeed, the resistant condition and the expression of deep misery is to my mind typical of their malady.

What then is the exact condition in these cases? The patient can feel, his reflexes are present, the sphincters act normally, each can swallow, and is certainly not paralysed, so that there is little doubt as to the condition not being involuntary. It is almost certain that the state is one resulting from intense volitional exertion, inhibiting all the usual movements that respond in normal people to external or internal stimuli, and the only reasonable supposition is that a still stronger efferent impulse is continually working that excites the control and overpowers the normal impulses that fail so signally.

Most of these cases in which a clear history can be obtained show that they result from an antecedent condition of melancholia, which rapidly increases; the patient from merely being



depressed becoming more intensely so, then becoming more morose, gloomy and taciturn, until this culminates in the state of absolute silent immobility and non-reaction to all impressions that we see in this disease.

These clinical facts agree with the theory advanced that most of these cases are varieties of melancholia, that they result from an overpowering sense of dread or, as some assert, from a delusion, in accordance with which the patients voluntarily maintain the condition described.

All the patients that I have seen on recovery (and these cases usually recover, when they do not die of some intercurrent disease such as tubercle or diarrhoea) maintain that they had perfect consciousness and memory during the time of their immobility, and often assert that they were compelled to act as they did in consequence of some great dread or great depression and sense of misery or some powerful "feeling" which they could not help but obey. Some of the Katatonic cases have a definite memory for only part of their illness.

It is asserted (Clouston, *Mental Disease*) that in these cases the "power of receiving impressions from without is in abeyance" and that the "higher reflex functions" of the brain "are suspended," but I would submit that there is no evidence of this, but rather that the stimuli, the impressions on the senses which produce no effect, fail to do so not because they are unfelt, but because the reaction they normally excite is inhibited. A careful repeated examination of these cases gives one the strong impression that there is not the slightest defect in their transmission, just as one is easily satisfied that the skin and other reflexes are unaltered. Certainly, on recovery, the patients usually profess to have been conscious of all the efforts to arouse them.

It will be noticed that, so long as the patients are regularly and forcibly fed, with sufficient quantities of nourishing food, the general health is often maintained, and, indeed, the body weight may be seen to rise.

The only general defect that may be intervened is a certain amount of coldness and blueness of the extremities which look a little blue. The general body surface, unless allowed to remain exposed, retains its usual temperature; bedsores do not form nor do any trophic changes take place. There is, however, a marked feebleness of the circulation, the pulse is small, soft and compressible, and it is occasionally to be seen, when recovery is about to

take place, that this is preceded by a gradual improvement in this respect, the pulse becoming fuller, stronger, and quicker.

Most of the patients suffering from the disease are young. Indeed, you will never see one of over middle age, and Dr. Clouston lays particular stress on the fact of the malady occurring always in the actively reproductive period of life, but the absolute inability to obtain any "previous history" which is such a marked feature in this country, renders it impossible to say whether in these patients, at any rate, the commencement of disease had any connection with sexual excitation. When any history at all is forthcoming, it is, on the contrary, one of rapidly deepening melancholia, for the onset of which no explanation is available. Some of the cases present a certain amount of catalepsy, but this is so variable and changeable that it does not suffice to make a variety of the disease. It has, however, been attempted to separate a form of "anergic stupor," in which the patient, outwardly the same in appearance, is quite passive, unresistive and with absolute loss of consciousness and memory, often accompanied by vasomotor and trophic lesions. Such cases are seen, and though sometimes described as occasionally passing over into the more typical forms, there is little doubt belong to these rare cases of "acute dementia," a condition of functional, temporary or permanent arrest of volition and intelligence, an arrest of brain function quite different from melancholic stupor, in which obstinate resistance with retention of memory and consciousness are marked and indeed essential features. In acute dementia there are, too, altered reflexes, and there is much more loss of facial expression, and there is an abolition of emotional, intellectual, and volitional operations through functional arrest or destruction of the cerebral mechanism, by which they are normally rendered evident as opposed to the inhibition of these manifestations seen in cases of true melancholic stupor. The two diseases are quite distinct, and indeed radically opposed. It must, however, be remembered that the insane presents a wide gradation in states of stupor, beginning at cases of mild "melancholic" apathy and ending in those here discussed, and that it is necessary to distinguish them from the modified forms of stupor seen in those cases of the secondary, transitory stupor after acute mental disease (to my mind most resembling modified dementia), a form which all are liable to be followed by, and in which, for a short period, the patients are confused, inattentive, lethargic and torpid and

present an abeyance of all the higher reasoning powers—a state of stupor from brain exhaustion often seen when the attack of acute mania, etc., has just passed off and precedent to recovery.

I have had several cases in my experience where a condition of professed melancholic and also Katatonic stupor has arisen after a great shock. I have seen it twice in men under sentence of death (in one of these cases the man was afterwards proved to be innocent); once also after a great family disgrace had befallen a man of high position. It is obvious that, as actually happened in one of the men convicted, a strong belief may be entertained that the disease is really only an example of malingering.

These cases, however, do not develop instantaneously but gradually appear during the course of several days; this is an excellent criterion. Being prisoners, their condition can be seen daily and they will show a gradual transition from mere dejection and depression through silence and slowed movements to rigid immobility and stupor; in the case of a medical man or asylum attendant such a sequence possibly might be stimulated, though it would be extremely difficult even in them, but it is obvious that in a foolish stupid Jat or Sikh such an assumed condition would be commenced within an hour or so, and this is never seen, also the absolute indifference to all stimuli is very characteristic; these patients may be pinched, struck, burnt, the nostrils or ear may be irritated and at most a flickering eyelid or reflex contraction of the forehead will result. And, on the other hand, as exactly similar cases of stupor arise where there is no reason for malingering, the possibility is extremely unlikely. To a non-medical man, however, the regarding of some of these conditions as stimulated is very excusable. No two cases are exactly alike, and it sometimes happens, especially in those Katatonic cases, that if they are left alone with food placed beside them when they believe themselves alone, they will rise and take it; others will get pass their excreta on one side so as to avoid soiling themselves. It was facts of this kind that were so strongly urged as evidence of malingering in the criminal cases referred to, yet curiously at the same time there were in the asylum two other cases, a male and female, both of whom did exactly the same, and in neither was there any possibility of the disease being stimulated, and I had previously seen another case in which the same peculiarity was noticeable.

In addition to the varieties alluded to there are also some conditions of flaccid "unconscious" stupor following attacks of convulsions or "congestions" in general paralysis of the insane and epilepsy, sometimes indeed seen without the convulsion associated with much brain atrophy. These attacks are, however, of short duration, and more of the nature of coma or of mental obnubilation resembling the mental confusion experienced by some people when half awake. A similar condition is sometimes seen in alcoholic insanity, and a mild form of stupor immobile, only differing in degree and duration from that of melancholia attonita, is also seen sometimes following great mental shock of sorrow, grief or joy—a condition that has obviously given origin to the common phrases "transfixed in horror," "dumb with terror," "rigid," "petrified," etc., etc.

It can only be very slight and modified cases that require distinguishing from the conditions alluded to by Bevan Lewis as resulting in stupidity and torpor from obstruction of the nasal passages from adenoid growths, in which the patient becomes heavy and stupid, has a wandering gaze and stupid expression with the impeded respiration causing an open mouth often with dulled hearing.

It is, however, a disputed point whether conditions seen in hypnotism, the somnambulistic and cataleptic states and the more profound conditions of mental lethargy are only differences in degree from mental stupor; certainly some of these are best explained by the theory of one dominant idea overpowering mental operations and inhibiting the operations of all others, but all hypnotic subjects, speaking broadly, are "susceptible to suggestion" and obey readily, commands given in that way—the exact opposite to cases of melancholic stupor in which the very reverse holds and is indeed an essential characteristic.

There is little doubt that many of the cases of trance, etc., so often found in literature, would, if examined, be found to usually consist of people suffering from this disease, which, from its striking peculiarities, lends itself well to description and the sufferers from which must always have excited great interest. There are a large number of cases of the disease reported, but I am not aware of any one having succeeded in finding any characteristic appearances *post-mortem*, and I have certainly not been able to do so.

Appended is a brief summary of the differential symptoms, etc., of the four chief varieties of stupor.

**ANERGETIC STUPOR OR ACUTE DEMENTIA.**

Onset sudden after shock or fright.  
Condition of immobility, silence, absence of spontaneous movements, cold and blue extremities.  
Passage of excreta beneath the patient.  
No display of emotions.  
Patient non-resistant and apathetic.  
Does not ask for food but eats readily if given him.  
Pulse feeble and infrequent.  
Buccal mucous membrane often ulcerated.  
Tongue furred.  
Breathing slow and shallow.  
Lessened respiratory murmur.  
Catamenia absent.  
Complete loss of memory for illness on recovery.  
Trophic changes. Pustules, etc.  
Hair dry and rough.  
Opacities and grooves form on nails.  
Body weight lessens.  
No rigidity of muscles.  
May be *flexibilitas cerea* (only apparently so).  
May be extreme anæsthesia over large area persistent for long.  
Physical health bad.  
If speech possible, patient will be found disoriented.  
Duration variable, may last for months.  
Result, fair recovery in most cases.

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**MELANCHOLIC STUPOR.**

(SYN.) MELANCHOLIC ATTONITA.

Gradual onset from Melancholia.  
Condition of immobility, silence, absolute refusal of food.  
Passage of fæces under patient who is regardless of anything.  
Will allow his face to remain covered with flies without movement.  
Expression of intense dejection.  
Strong passive resistance to everything.  
Food refused.  
Pulse small, feeble, usually slow.  
Mouth and tongue cannot usually be seen.

No constant peculiarity of breathing, though often it is slow.  
Catamenia often absent.  
Usually perfect memory on recovery.  
No trophic changes, and if patient fed regularly by nasal tube, may gain weight.  
Proximal joints and trunk muscles rigid.  
All muscles frequently rigid to some extent but above most markedly so.  
No true anæsthesia, but no reaction to any form of sensory stimulation.  
Complexion may be sallow and mucous membranes anæmic.  
Lower lip often pendulous and full of saliva.  
Gummy exudation often from eyelids.  
May last 18 months or 2 years, usually 6 to 12.  
Recovery complete in majority if phthisis does not set in.

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#### POST-MANIACAL STUPOR.

Gradual onset from Mania.  
A patient is more stuporose than really in a state of stupor; he can be aroused by loud shouting and stimulation, but then relapses.  
Will sometimes react and reply slowly to questions.  
Excreta may be passed in carelessness in clothes, not regularly.  
At times some voluntary movements are made slowly and as though with fatigue.  
No resistance to movement.  
No peculiarity of pulse.  
No peculiarity of mouth or tongue which can be seen.  
Breathing normal.  
Catamenia usually present.  
Memory on recovery hazy.  
No marked trophic changes, but general weakness, dulness, and apathy as though on recovery from a severe illness.  
No rigidity of muscles.  
May be some anæsthesia on periphery of limbs, but this transitory.  
Duration short, a few weeks at most.  
Good recovery usual.

## KATATONIC STUPOR.

1. Rapid onset.
2. Patient rigidly immobile, resistant, often in some peculiar position, mute, resistant, passing everything under him; this is sometimes broken by some sudden impulsive movement.
3. Rigidity of muscles; may oppose every effort at movement or examination.
4. Food absolutely refused.
5. Patient may be lifted up in same position that he maintains when lying.
6. On recovery part of illness frequently not remembered.
7. Mouth and tongue cannot be examined on account of opposition to opening mouth.
8. Often profuse salivation.
9. No reaction to any sensory stimulus.
10. Some cases when unobserved (as they believe) take food put before them and rise for purposes of nature.
11. No trophic changes.
12. Physical health if fed good.
13. Muscles rigid all over body and active opposition to all passive motion.

If history obtainable, periods of excitement preceding this, also of grimacing stereotyped movements, automatism or verbigeration or some frequently repeated cry or sound.

(Flexibilitas cerea at any time very frequent) or of illness having commenced with a period of depression *plus* hallucinations. Duration may extend to 18 months.

Recovery (partial), frequent.

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 CHAPTER XIV.

## DEMENTIA.

Dementia—a loss of faculties (*sic*) or powers of the mind in a patient who was formerly in possession of them as opposed to “idiocy” in which to all intents and purposes the patient never had them. In other words, a patient, formerly of sound mind, who has lost his memory, his powers of intellect and volition, in whom ideas, affections and determinations are utterly expelled, whose mind is apparently utterly destroyed, he, we say, is “demented.”

He is in the same condition as an idiot (indeed such a one may be said to be suffering from amentia), but differs from one in that he formerly was in possession of these faculties which he has now lost, he having become progressively more and more weak-minded. Dementia is that condition, the goal, into which drift all long-continued cases of insanity, though it may follow a very rapid attack of short duration and is occasionally seen to arise after some severe shock, etc., as a primary and acute affection; as a general rule, however, it is, as already said, secondary to chronic insanity or a preceding acute insanity and is then very gradual in its origin, and this explains the fact that every variety showing less or more evidences of mind, existing, may be seen, and that the typical clinical condition of loss of all the higher functions of mind and of the individual being reduced to a mere automaton dependent on the care of attendants for his preservation is not often presented.

It must be remembered also that Dotage is natural to the majority of individuals at an advanced age and that a condition of weakmindedness, temporary or otherwise, is seen after long and intense privations, endured on long journeys, during prolonged sieges, etc., in the process of starvation to death, from the shock of intense strain, business crises, sudden emotional shocks and after direct injury, blows, etc., to the head—and such cases are only varieties in degree from ordinary secondary dementia. Exactly the same symptoms are seen after prolonged alcoholic habits and in some severe cases of syphilis and as a result of primary (?) brain disease, tumours, etc., cerebral hæmorrhage, in softening senile atrophy, etc., and in some cases of epilepsy.

A temporary form is met with sometimes in the exhaustion that follows acute mania, especially if this has been associated with pneumonia, also after prolonged fever, and it is said to have been seen after childbirth: these, however, are mild cases characterised by apathy, indolence, self-neglect of cleanliness and appearances, want of initiative with a disposition to sleep and eat much and to become fat, and generally become soon cured under treatment.

Ordinary secondary dementia more frequently follows mania than attacks of melancholia, and its risk is practically in direct ratio to the length of the attack it follows. In dementia there is a general enfeeblement of all the powers of mind; there is inability to reason, feeling is diminished, the senses seem to react slower to their respective stimuli, and there is lessened power of



volition and inhibition; there is failure of memory and a want of attention, interest or curiosity; even the power of strong impressions seems to be impaired or annihilated; there is rarely any display of emotion, and the powers of abstraction and capacity to judge by comparison is wanting; nor is there any origination of ideas.

The condition, it must always be remembered, varies in every degree from a mere intellectual dulling to a complete loss of all intelligence, volition and memory. Also it must always be remembered that the same amount of disease will vary in its effects with the original mental grade, or, in other words, that the same amount of loss will affect less a very clever individual. If you take any well-marked example, you will be probably shown an elderly man who, after suffering for many years from chronic insanity, most probably mania, has gradually passed into the condition in which he now is—he will be probably sitting apathetically aside, listless, taking no interest in anything, paying no attention to anything, never speaking unless addressed and even then you will find that a strong stimulus of voice and gesture will be needed to arouse him when he will slowly raise his head, look dully around and perhaps answer by a monosyllable. He may not know his own name and will probably have no idea of where he is, or of how long he has been there, or what he did the day before; in a word, he has lost all his memory for recent events; that for occurrences of his childhood and times long past may, as so often happens, still remain. You will see that he obeys any order no matter by whom it is given; he has no will of his own and can be led about like a little child and is totally devoid of that tendency to opposition to and contrariety so often seen in insanes; he cannot reason or judge on any subject, it is difficult or impossible to carry on any sustained conversation with him; he desires nothing; if food is given him, he will devour it often carelessly, dirtily and voraciously; has no idea of caste principles; he will sit there the whole day, perhaps, carelessly picking his face into sores, basking in the warmth, and, were he not moved into the sleeping quarters, would stay there the whole night; were he not brought food, he would not demand it, though, unlike a man with melancholic stupor, he does not refuse it when he sees it and has good digestion and appetite.

He passes his fæces and urine under him where he sits or lies; if he is half naked, he will make no attempt to cover himself and is

dead to all the ordinary rules of conventionality or politeness in which he may have formerly been well trained. He shows no sexual desire, no desire indeed to do anything and never asks for anything. The face may present nothing unusual, but if he be aroused in some way, the look of utter deficiency of intelligence and volition is seen to come over it at once. The circulation in advanced cases is often poor, the hands blue and cold, the muscle flabby, and even common sensibility seems diminished. The reflex actions are so variable that nothing certain can be said of them.

His whole condition shows an absence of the powers to initiate anything or to oppose his will to that of others. A man with melancholia may be incapable of being aroused, lies the whole day in one position and in many ways resembles an advanced dement, but a little investigation will show that he is in a condition of active opposition, as, unlike a sufferer from dementia, he resists treatment, will not eat if food be given him even ; will not obey and is obviously in a condition of emotional strain ; he is always resisting, while a dement resists nothing. Even in cases of advanced dementia it is wonderful how even with complete loss of memory and apparent cessation of all volition how long the capacity for emotion persists. We had here a patient in the last stage of dementia from epilepsy, aggravated by prolonged alcoholic excess, incapable of anything for herself who from time to time, nevertheless, when some memory of events long passed, aroused in some inexplicable way, flashed across her brain, would break out into a storm of passionate weeping or powerless anger.

The cases of complete loss of intellect, intelligence and volition are comparatively rare, and in practice every gradation can be seen, commencing from simple lessening of reasoning power, slowing of the mental processes, the patient, if spoken to, being difficult to arouse, taking long to answer, being slow to think, dull and apathetic, having lost his capacity for work, his ability to be taught anything, a gradual dulling of his hopes, fears, affections and wishes to the fully developed variety when he is seen either sitting motionless and apathetic or, if aroused and finally made to understand, he walks with shuffling gait and attitude of lessened vigour with poor circulation and flabby muscles ; he does not know his own name and cannot tell where or who he is ; he will forget even his own food, resists no one and obeys every one, and wet and dirty seems to be fast becoming a human automaton. In such cases, with attention life

may be very prolonged ; being freed from the anxieties attendant on the possession of feelings, emotions and desires, he may linger for years, even grow fat, sleeping well, paying no attention to anything or anybody. As so many of these cases follow mania, a large proportion are seen whose gradual course of mental decay is accompanied by some of the residua of the mania they originally suffered from, some delusion, a curious or insane habit, a tendency to chatter incoherently either to themselves or when aroused, or from time to time their even tenor is broken by fits of restlessness or bursts of anger ; very many are given to being noisy at night though quiet during the day, but gradually all these become less and less prominent ; the insane chatter is only shewn when repeated questioning may arouse them to speak, their fits of anger become fewer, and at longer intervals, and the symptoms of pure dementia from weakness of intellect and volition come to be more and more evident and marked, and ultimately entirely replace the precedent condition.

Cases of dementia are, of course, quite incurable, but it is possible, though very rare, to have an acute (curable) dementia following some great mental shock, as fright, in those disposed by heredity to insanity ; in these cases the symptoms are the same and the history of sudden onset with a total absence of any residua of acute symptoms or previous maniacal condition is the only criterion. Patients with this affection are generally young or in adult life and they frequently recover (such cases must not be confounded with those of mental stupor) ; a still further variety is seen in this country where the disease is primary and of gradual onset, and this is not confined to those having a neurotic heredity. It follows prolonged mental strain and anxiety, and worry of some exhausting character, especially if this is combined with prolonged mental exertion. At the commencement little is seen, but an inability to perform some special duties, a few details of which the unfortunate patient may have acquired with much labour, for these people are of those forced to make up with plodding industry their want of natural quickness and ability (often those who are trying to "rise" from a low station). If a student, he feels that even careful and repeated reading will not enable him to grasp the details of his study ; that he forgets rapidly, is becoming stupid and incapable of "grasping" a subject ; he suffers with severe headaches ; should he be warned in time and take absolute rest and change of scene and occupation, the old

ability may return; but should he, as so often happens, continue to weary an already exhausted brain, there is progressive failure of memory and loss of power of attention and general enfeeblement, mental and bodily, total absence of energy—usually plus persistent insomnia; even in very pronounced cases of this kind, recovery is possible with prolonged rest and treatment, though some, especially if this has been much delayed, remain for years absolutely unfit for their former duties and in a helpless condition of mental failure or are carried off during the period by some intercurrent disease; but it is rare for such to pass into the stage of complete dementia so often seen after chronic mania, although occasionally such cases, after several years in their original condition, develop mild maniacal symptoms, become very destructive and restless, and even after these appearances recover.

Finally, it must be borne in mind (1) that in all cases of dementia of secondary origin its occurrence has no certain relationship to the intensity or duration of the preceding attack of insanity; (2) that every variety of mental failure may be seen from simple lessening of ability to the most pronounced and absolute loss of intellect and volition, and that occasionally (rarely I allow) only one factor of mind may appear to be affected—there may be an absolute loss of memory—an inability to fix attention or to initiate anything; (3) that the cases most liable to end in secondary dementia are cases of adolescent and prolonged insanities, especially those in which masturbation has been excessively indulged in, whether the latter preceded the insanity or was one of its earliest symptoms.

After all these qualifications, it must, however, be owned that experience teaches us that no attack of acute insanity ever leaves the mind and personality quite the same as it found it: we may and do return them as cured, but there is always a mental scar, a defect, a loss perhaps perceptible only to those intimately acquainted with the patient, but there it is, and such an effect can only be regarded as a degree, however mild, of secondary dementia which it may therefore be held always follows any acute mental affection.

In Europe I regret to say more commonly than in this country a definite disease consequent on excessive indulgence in alcohol is frequently seen. Like other diseases connected with this habit, it is most common after excessive and prolonged

indulgence in spirits in contrast to that in wines and malt liquors.

Though not unknown in this country, it is infrequent, and its incidence too is relatively less than among Europeans, even in drunkards, which is peculiar; as spirits and those often of bad quality are the only form of alcohol with rare exceptions ever indulged in by the natives of India while in the country. In them too it is often obscured by the results of *charas*-poisoning. The patients usually present the bodily symptoms associated with alcoholism, tremors specially marked in the hands, lips, and tongue (often relieved temporarily by alcohol); muscular weakness, in some cases the signs of peripheral neuritis, the ectasis of capillaries often plus the signs of chronic, hepatic and renal disease.

The dementia is not absolutely characteristic but is always attended with a marked loss of memory which is often the primary symptom, and is always of gradual onset. This is often also attended with the peculiar symptoms so commonly seen in chronic alcoholic insanity, the fearsome hallucinations, the "visions" of snakes, insects, vermin, etc., the delusions of sexual persecution, marital infidelity, etc., of being poisoned—perhaps this latter arising from the chronic catarrhal condition of the stomach—all of these being also attended with the special bodily characteristics so often seen in chronic alcoholics, the weakened lax muscles, the hanging head, the bent knees, the dulled eyes, and expressionless facies. As the tendency to give way to alcoholic excess is most frequent in those of neurotic inheritance, it is not surprising to find this condition often marked by other "neurotic" disorders, epilepsy, idiopathic or as the result of alcoholism—cerebral apoplexy from renal disease perhaps being the most frequent. Thus, too, as a consequence of the habit, loss of money and position ensues, all tending to accelerate the degradation which culminates in the volitional enfeeblement and moral weakness typical of such people. When once the habit is firmly established, all thought of family or self-interest is sunk in the one absorbing desire to obtain the alcoholic stimulant which, for the moment, it is true, temporarily relieves such a one from the emotional depression and the tremors which he suffers from. As the condition becomes more extreme, the intellect becomes more enfeebled, the volitional power more impaired, all initiative is lost, and the patient lives in a condition of apathy, only broken by his recurring desire for the drug which has caused it all.

The bodily consequences and sign of long continued alcoholic excess are undoubtedly more prominent in Europeans. One sees here often the most marked cases in natives of the country and yet fails to find in them any capillary ectasis for example or any signs of renal or hepatic disease. The mental symptoms, the morbid enfeeblement of memory, etc., are of course there, but the bodily changes are frequently limited to a pallid, flabby, pasty facies, morbid muscular enfeeblement and some fine muscular tremor. Alcoholic peripheral neuritis is, however, often met with and its pains and tenderness and the usual restriction of these to the muscles of the lower limbs is often marked. The delusions of persecution and marital infidelity are in my experience very rare among natives, nor am I able to give any explanations of these racial peculiarities.

We may then classify Dementia as—

(I) Primary if acute or of gradual onset ; recoverable from.

(II) Secondary most common after prolonged mania.

(1) Melancholia not so frequently causing it ; incurable.

(2) After Epilepsy, incurable ;

(3) „ Syphilis, sometimes can be ameliorated ;

(4) „ Alcoholism „ „ „ „

(5) „ Direct injury, blows on the head, rapid onset, recoverable from.

(III) Senile Dementia if gradual and of primary onset in old age, incurable.

(IV) Organic from gross brain lesions, apoplexy, softening, morbid growths, necessarily of fairly rapid onset, and incurable.

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### *Senile Dementia.*

Though melancholia is very frequent at advanced age and sometimes a form of mild mania is seen, then the typical insanity met with at that period of life is dementia with certain characteristic symptoms and others that are really exaggerated natural phenomena. Pure senile dementia is a gradual primary mental deterioration occurring in aged people to be distinguished from that which sometimes follows cerebral apoplexy, softening or other brain diseases which are relatively more common in late life. It is generally found associated *post-mortem* with a general atrophy and degeneration of all the tissues of the brain which

may weigh 2 to 500 grains below the normal—an increase in the cerebrospinal fluid, thickened and adherent membranes, reduced convolutions with widened fissures and especially by atheromatous and degenerated vessels which may often show miliary aneurisms. With these microscopically there is atrophy of the cortical nerve cells, especially in the frontal and central gyri which are in some cases extremely degenerated.

With advanced age a certain amount of dotage is usual or at least not uncommon, and old people are markedly conservative, lethargic and frequently economical having learnt by experience the necessity for such habits, but in the senile dement these characteristics become exaggerated, the lethargy becomes absolute weakmindedness, the conservatism degenerates into suspicion and the habits of careful economy into penuriousness and avarice from which are frequently evolved delusions of attacks on their property; also they become egotistic and selfish, forgetful of all ordinary conventionalities, lose their former self-respect and politeness, become dirty, irritable and self-absorbed. They become emotional, varying between at one time elation and the other depression. In some there is an outburst of sexual desire and an old man of 80 will be seen marrying some quite young girl, and others will show a moral deterioration and give way to vice and develop bad habits. The avarice is a very marked feature; he will believe and declare that all are conspiring against him to rob him of his hardly earned wealth; he constantly contrives new hiding places for it; is perpetually changing his agents and bankers and becomes suspicious of all around, more especially of his relatives who, he imagines, are only waiting to see him die so as to inherit his wealth, this being the case of so many altering their wills and leaving immediate relations penniless to bequeath their all to charities and strangers, and such men are particularly open to the designs of designing people.

The greatest characteristic of senile dementia is, however, the progressive loss of memory at first only for recent events; the patient will forget having seen a person an hour before though he will remember minute details of his past life.

But as the malady increases, their loss extends further and further back, still further adding to the individual's dulness and stupidity and incapacity for affairs, until finally the names of relatives and even children are forgotten (it is obvious how this fact may tend to "will" litigation), and they may lose their way in their

walks and not recognise even their town or village. With this there is increasing dulness and difficulty in comprehension; the patient has a difficulty in understanding the simplest facts; he makes foolish and incompatible statements, will declare he is 30 years old and yet claim to have 15 children, the eldest of whom is 40, etc., etc.; he will call those present by the names of people living or dead in his childhood. Prolonged irritability is very common. At any time delusions usually of suspicion and ill-treatment are common, though these are generally fleeting and of an unsystematised character; they believe plots are evoked to defraud and rob them, as a result of which or even without them they become lachrymose, anxious and restless, and here it may be added that though these patients may sleep most of the day, they are frequently very restless at night, continually walking about, never still, persisting in occupying themselves, thus keeping everybody awake and being in that way, particularly, a great annoyance and burden to the rest of the household. Almost all lose their appetite entirely.

Such patients also show the changes incidental to old age in a most marked manner, such as arcus senilis, also cataract with hard tortuous temporal arteries. With these there is frequently muscular tremor and complaints of occasional vertigo and an ever-increasing weakness and loss of health and vigour not readily accountable for. There is later progressive feebleness of limbs and weakness of sphincters, the patients often passing their excreta in the bed, while the pulse is typically feeble, slow and irregular.

The disease is of necessity incurable and life is usually not long prolonged, once an advanced condition has set in.

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### *Organic Dementia.*

By this is meant (or under this term is usually included it would be perhaps better to say) any mind defect following injury or disease of the brain obvious by injury, the symptoms of its occurrence or visible *post-mortem*.

It may be taken as certain that no brain disease or injury can occur without some sign of mental impairment, but the defect may be so slight as to cause it to be overlooked, or the lesion so local that only one defect may follow, and this being compensated for by



the remainder of the cerebrum—unless its mental signs are carefully looked for (which rarely happens); these are unrecognised. Still they are always there in every brain affection.

Cases of insular (disseminated) sclerosis for instance may seem to offer an obvious exception, but it will be noticed that in all the patients are, as it is said, “very emotional” (the same by the way is true of cases of hemiplegia of sudden onset and always of labio-glosso-pharyngeal palsy (Bulbar paralysis)). Towards the end there is also usually a certain amount of mental deterioration and in very many forms at an early period in this disease (insular sclerosis) the patient is distinctly silly, heavy, dull, does not understand things well, the memory is not so good as before, or there may be attacks of mild excitement and emotional outbursts, while in others the condition is so pronounced that the patient is practically demented. In tumours of the brain the mental symptoms are in direct relation to the rapidity of the growth; if this be very slow, they may be very slight, but some are always to be found; speaking generally, these consist of dulness, a general apathetic condition increasing to lethargy, a certain indifference to passing events, a condition aggravated of course by the special symptoms of its position, the loss of sight, smell or hearing, the word deafness, the convulsions and the persistent headache which are so common. Very common too is a condition only to be described as “confusion” passing on into delirium; mental stupor advancing to complete dementia or a delirious condition resembling that of a toxic psychosis is not at all infrequently characteristic of advanced cases just as general mental dulness is of the early stages and weakness of memory at any period. Hallucinations are occasionally seen and are generally indicative of disease of the corresponding sensory centre.

Tumours of the frontal region are specially prone to exhibit intellectual defect or change in personality and in moral behaviour.

These remarks apply equally to cerebral abscess which in this particular can be regarded as synonymous with tumour. Abscess is, perhaps, more frequently attended with stupor than other mental defect, though I have seen marked hallucinations of taste and smell with a large abscess in one temporal lobe.

In Cerebral Hæmorrhage and embolism if mental symptoms are seen after the recovery from coma, these will generally be of confusion, stupidity and dulness; the patient does not recognise

where he is, is very confused and frequently restless, anxious to wander or move about, resents all examination or interference, is petulant and irritable, he may commit absurd acts, mistake people and is often wet and dirty. This may continue or after they become, as they usually do, quieter and recognise their surroundings, the memory will be found profoundly affected and, curiously, often of events in their past life, or it is lost in some special manner; they cannot calculate time, remember names, etc. The condition is of course much complicated by, and its examination rendered more difficult by, co-existing aphasia and word deafness. All hemiplegics, even when otherwise sane, show defective control over their emotions; they laugh and cry very readily, but in those with marked intellectual defect the condition fluctuates—at one time the patients are dull, heavy, apathetic, at another irritable and quarrelsome, at yet another dejected and lachrymose, and the whole state may be varied by transient attacks of excitement and garrulity.

Sometimes, on the other hand, the result of an apoplexy is a complete change of disposition. The sufferer becomes selfish, impolite, egotistical, dirty, untidy, will wander continually about naked, or he becomes changed morally, and a sober, well conducted man will end his days in vice and self-indulgence.

It is important to remember that head injury, blows, falls, etc., and insolation may be followed by marked mental symptoms. The initial period of coma, which usually supervenes in them, is followed by a period of semiunconsciousness which may last up to several weeks. The patient is "dis-oriented," has no idea where he is, what has happened to him, or who are about him, has completely lost his memory for both present events and often for everything that concerned him for some period before his illness, though equally curiously, like some alcoholics, they show a tendency to fabrication. A patient lying in bed for the past week will give a calm, dispassionate, coherent account of a visit he paid and acts he performed while out the day before. They seem to find it difficult to think and reason; are always slow, heavy and dull; though at the same time often very irritable and still more frequently restless, always wanting to wander about and objecting to be still. In a few cases loss of memory for a long period is the only symptom exhibited and this may (rarely) be recovered from.

On the other hand, instead of symptoms immediately follow

ing the injury, the patient may apparently recover after perhaps an initial period of unconsciousness, etc., but in a little while the man or youth is noticed to be changed, though he may be so only morally and in intellectual capacity. The former bright youth is wayward, unable to learn, does not much wish to do so, spends his time wandering foolishly about, taking pleasure in childish amusements, is very forgetful and quite unable to follow his usual occupations; with this there is often great fatigue on the slightest exertion, he forgets everything, is very inattentive; though perhaps formerly bold and enterprising, is now shy, timid, and retiring, is depressed and childishly irritable, with deficient self-control. The condition is incurable, though the individuals often show transient remissions or, what is perhaps of more importance, suffer from exacerbations of waywardness and incapacity.

Just as head injuries in alcoholics and syphilitic subjects are the most likely to be followed by mental disturbance, so it must never be forgotten that all people who have once suffered from head injury or insolation are remarkably intolerant of alcohol; in them a very small quantity will produce violent drunkenness and in some a transient attack of mania. Such patients must practise rigid abstinence in this respect. The diagnosis of all these Organic Dementias lies in their history, the signs of injury or the existence of hemiplegia or other paralysis and the symptoms of Organic brain disease. It is not usually a matter of great difficulty.

The importance of this point is sufficient excuse for my specially pointing out the care that must be used not to regard a case of disseminated sclerosis or of brain tumour as one of hysteria; a mistake that has often been made. A still later condition arising from injury may perhaps be alluded to here, and that is the one usually described as traumatic neurasthenia which occasionally follows on accidents which may not even have been attended with obvious signs of injury, or if so, of slight ones only. It frequently only arises after some interval has elapsed after their occurrence. The patient complains of marked incapacity for any exertion or for following his usual occupation, suffers from fatigue over any sustained effort or he has some particular obsession or fear, is always complaining of insomnia, vertigo and general fatigue, of feeling an incapacity for anything, of a loss of control, of weakness of memory, though this on examination may be found unimpaired just as no objective signs can be found for the other condition, though careful examination of his intellectual capacity, as

compared with his past power and that of others of equal standing will reveal a deficiency. With all this are various hypochondriacal notions and complaints of pain at the seat of injury, and the mind as a whole seems to revolve round the accident, and the patient's feelings and conditions and to be incapable of being exercised in relation to others, or to the environment.\*

The diagnosis of the disease is far from easy and is of great importance as these cases are so often the source of litigation in regard to compensation.

Organic Dementia may therefore follow—

(1) Any brain disease.

(2) Disseminated Sclerosis.

(3) Cerebral Tumour and Abscess.

(4) Bulbar Palsy.

(5) Cerebral Hæmorrhage and Embolism producing then—

(a) General mental effects or

(b) Change of disposition.

(6) Head injury producing then—

(1) General condition.

(2) An immediate change of personality and disposition.

(3) Simple loss of memory.

(4) Traumatic Neurasthenia.

## CHAPTER XV.

### DEMENTIA PRÆCOX—(*Adolescent Insanity*).

The name of Dementia Præcox has been of late years given, especially in Germany (Primary Dementia in Italy), to a group of cases commencing in early life of a chronic course, fundamentally characterised by a progressive mental deterioration ending in more or less complete dementia; although much objection has been taken to the term (chiefly apparently on account of some of the cases being met with in advanced life) and though the pathology is more than uncertain, the group forms at least a well defined clinical entity and is of undoubted occurrence. It is usually subdivided into Hebephrenia, Dementia Paranoides and Katatonia. In at least 70% there is a definite neurotic heredity in some 10%; it seems to follow more acute disease, fever, etc., and in a still smaller proportion head injury. Many of the patients show the physical stigmata of degeneration so common among idiots and epileptics, and many have been in childhood of the type described as "peculiar," "exclusive," showing

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\* Cases of Dementia Præcox are sometimes seen in young adults who have a year or two previously had severe head injury; in my experience these are always cases of injury to the frontal region of the skull.

precocious piety or the reverse, impulsiveness and great susceptibility to the effects of alcohol. According to some observers the disease often bears a relation to onanism, and certainly its onset is frequently coincident with the commencement of sexual vigour. It is noteworthy that one variety (Katatonia) has been occasionally seen to arise in weak-minded people—the only kind of insanity that I am aware of ever affecting them. Roughly, it may be looked upon as a form of mental abiotrophy, if such a term is permissible, though it is often regarded as a form of auto-intoxication, but nothing is definitely known in this particular. The onset of the disease is either very gradual, following a little headache and insomnia. This being succeeded by a gradual change of disposition; a loss of activity and energy, the patient becoming silly, shy, irritable, obstinate and careless; unable to follow his occupation or, if it begins more rapidly, doing so usually with a period of depression, apprehension, and suspicion, with it may be a foolish attempt at suicide. The combination of this condition with some silly senseless delusion and hallucination, especially of hearing (more rarely of sight), being typical of the disease. In either case, it will be noticed that, when recognisable, the disease is shown clearly by a progressive impairment of attention and judgment by a condition of apathy of the emotions and disinclination for voluntary activity, that is very striking, and, above all, by what can only be described as a loss of interest in anything and everything. The patient being content to loll about, to stay in bed, indifferent to everything. He will not ask for any thing, unlike most other insanes; he will not resent being in an asylum, and he shows no interest in visitors and relations, taking anything they bring him apathetically and not asking to go away with them—yet, if questioned, such patients will answer—slowly and apathetically it is true but clearly; memory is not much affected (it is later); it may even be very good; they obviously know everything that goes on; they know where they are, and show good memory for past events.\* Still as the disease advances, it will be noticed that thought and ideation do begin to fail; that the patients wander a little, use silly phrases, cannot keep to the point; indeed, their silly, shy man-

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\* What seems peculiarly characteristic at least in Indian cases is the pre-eminently *silly* behaviour of the patient. He is always grimacing, mimicking or striking some foolish attitude or using some silly phrase in an affected tone giving one not cognisant with the disease an impression that he is "playing the fool," acting intentionally, etc., an impression often added to by the peculiar fits of chuckling laughter they also indulge in without obvious reason.

ner, the child-like way they have of grimacing, of having some curious mannerism or trick is very typical as is the curious "affected" tone of voice. One man will stand for hours in one attitude or in some silly posture, making continually the same grimace or will constantly repeat one particular action (an insane who has some well marked trick or mannerism, especially if this is a "silly one," is usually a case of *Dementia Præcox*). Others exhibit silly, senseless laughter with which they frequently seem to have no real mirth, it being more like the senseless chuckle of the congenital imbecile. Hallucinations, as already mentioned, are extremely common at the onset and are then usually accompanied by apprehension and dejection, but later they seem to be regarded without interest by the patients and finally appear to fade away. Some silly, senseless delusion is very common, and in the variety known as *Dementia Paranoides* this is the most well marked symptom. The youth will declare himself persecuted, unable to assume his lawful position, etc., etc., his delusions being strengthened by the hallucinations usually of hearing, that accompany it. But it will be noticed that this is apt to change, that the delusion is markedly of a silly character, that the emotional condition does not correspond; they will be half laughing while describing some dreadful persecution, etc., etc., they are subjected to, and the association of the hallucinations from the onset is very characteristic, and of course quite unlike that seen in true *Paranoia*.

There is at all times a marked deficiency of insight as it is termed and the patient cannot, like a melancholic, give one any ideas of his own on the subject of his condition; he is, indeed, so usually apathetic as to be totally devoid of interest in the matter. All are indifferent to their personal appearance, surroundings, etc. They will not wash or dress themselves, though they do not resist this being done for them; they will do nothing; they act, speak, behave and reason like a child, and a foolish one at that; coincidently with the progress of the disease there is a gradual failure of intellect and, sooner or later, all cases end in dementia, though this may be broken by remissions and an apparent (only apparent) recovery may take place; in rapid cases two years will produce complete dementia. In the variety spoken of as *hebephrenia* the disease begins so slowly that no definite period for its onset can be imagined, except that for some time the patient was noticed to change slowly, the character seems lost, or the youth changed in disposition only showing idleness, irritability

(though it may have originally been the opposite) which generally passes into absolute indolence and complete apathy; the patient will lie in bed all day, doing nothing, or will wander away careless of everything; if spoken to will answer in jerky monosyllabic replies or repeat the question before answering it ("echolalia"), or may give way to vice or self-abuse and obscene language, or write indecent letters; at some time or other early in the onset most become depressed and seem "melancholic," and this condition is usually accompanied by hallucinations; at any time the patient is untidy and careless of dress and cleanliness; he is frequently eccentric in that he shows some trick or mannerism, and retains the peculiarity even when the disease ultimately grows into permanent dementia. The manner in which among Europeans, when asked to shake hands they do so by jerking the hand stiffly forward from the wrist, is in them, for example, very distinctive. Hebephrenia is that variety of this disease most common in early youth, whereas, a little later, it is the Paranoid form (*Dementia Paranoides*). In this latter variety delusions form the most prominent feature, accompanied by hallucinations and that progressive mental deterioration common to all forms. The delusions are so prominent and persistent in fact as to cause it to be occasionally mistaken for true delusional insanity; they are usually of the nature of persecution, though others of grandeur may appear coincidentally, but the patients are peculiarly garrulous and given also to writing descriptions of their ideas, unlike the suspicious, reticent paranoiac who can only with difficulty be made to tell his story; also hallucinations, nearly always of hearing, are prominent from the first, while occasionally there may be some outburst of impulsiveness or excitement, but, as time goes on, they become more and more feeble-minded, the consciousness is clouded and ultimately the delusions seem to fade away or be unheeded. This form is very rarely seen in this country. The Katatonic form, however, is not at all rare in India. Though commonest here in the adult, it is also met with practically at any age up to middle life. It is well marked and was for a long time described as a separate entity. The classical description is of a patient who goes through a cycle of depression and melancholia, followed by excitement which in its turn is superseded by stupor, often for a long period; this too being peculiarly liable to be suddenly broken by excitement and restlessness and destructiveness and in its turn ending in an apparent recovery, a remission or dementia; of these, the

condition of stupor is the one in which we most commonly see them in India; and in this, as in every stage of the malady, certain peculiar symptoms are met with and which are fairly distinctive. Such being spoken of as stupor with negativism, automatism and muscular tension excitement with stereotypy and echolalia as in Kræpelin's description.

The patient is peculiarly resistive and negative; that is to say, that though he may lie or sit motionless and apparently in stupor, often paying no attention to skin irritation, a pin prick, pinch, etc., exciting no movement, yet if an attempt be made to move him, the muscles will be found firmly tensely contracted; he may be lifted up in the bent up attitude in which he was lying as though made of wood, and not only so, but there is usually on his part an effort made to do exactly the reverse of what is required: if it is attempted to open the eyes, he closes them; to open the lips, he clenches them firmly; if the patient is asked to stand, he will not; *vice versa*, if the hand is pressed against the chin backwards and suddenly withdrawn, the chin springs forward, showing clearly the active opposition, and often a desired action is only possible to obtain by asking him to do exactly the opposite; he may be induced to open the mouth by asking him to shut it, etc. Then also they frequently maintain for long periods one peculiar attitude; a patient will sit for days and weeks huddled up with his chin on knees or leaning against a seat with the head bent uncomfortably back or with lips pursed out and the nose wrinkled—the German “Snautzkramp; for they can be made to assume and maintain extraordinary attitudes by placing the limbs in that position; the so-called *Flexibilitas Cerea*, and, indeed, there seems to be in such a condition of peculiar susceptibility to suggestion; a patient will repeat anything said to him; if asked a question, he will, instead of answering it, repeat it; or some action done before him—hand clapping—will be repeated by him (*echopraxis*), and, as before remarked, a curious characteristic of the stupor is that, however profound it may appear, the patient may quite suddenly relinquish it, start up from his recumbent position in a state of wild excitement, rush madly about, tear his clothes, destroy articles or while in that condition repeat hundreds of times one monotonous word, cry or phrase; sway the head from side to side with the tongue out; stamp with the same foot continually in one spot for hours; make some curious sound, blowing through the nose some stupid cry, etc., for an indefinite period (*stereotypy*). Like every



other variety of *Dementia Præcox*, some peculiar trick or mannerism of a silly nature is exceedingly typical and frequent; and, on the other hand, though these symptoms above described are peculiarly frequent in *Katatonía*, some or any of them may be found also in *Hebephrenia* or *Dementia Paranoides*.

The stuporose condition may persist and, very profoundly, for many months during which time they frequently refuse food and have to be fed forcibly; its classical ending is for it to terminate in dementia, but I have in this country seen many cases which made a fairly complete recovery. I say fairly, for it must be owned that they were not quite the same as before its occurrence. They do not appear to be quite as active as before or to be of normal mental vigour, and certainly there are many who remain permanently sluggish, indifferent, without energy or intellect and rapidly show intense mental failure, and many, after a year or more of supposed sanity, return with a recurrence that ends in dementia. All varieties show great disturbance of nutrition; there is no appetite, the weight falls, they lose their colour, sleep is scanty, the heart's action is weak and irregular, and occasionally some vasomotor changes are seen. Cyanosis, excessive irregular perspirations, syncopal attacks, occur liable to be mistaken for hysteria or epilepsy, especially in *Katatonía*. The pupils are dilated and the tendon reflexes are usually much increased, while all the superficial reflexes are very easily obtained, and in women the menses are usually absent; while in some cases a diffuse enlargement of glands has been described. Respiration is almost invariably either very shallow or much slowed, while profuse salivation is common. Almost all the cases at an early stage lose control over the bladder; they are continually passing water in bed and in their clothes, and this too at a time when speech is still sensible and memory very fair. Retention of urine is never seen. The quantity, though often, appears to be excessive.

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## CHAPTER XVI.

### GENERAL PARALYSIS OF THE INSANE.

*Syn.* { *Dementia Paralytica.*  
       { *Paretic Dementia.*

Though this disease is, like *Tabes Dorsalis*, unknown among natives of India, it is met with among Europeans quite irrespective

of the length of their stay in the country, and a brief, a very brief summary of the disease is therefore necessary, though the majority of practitioners out here will never probably have an opportunity of seeing an instance of the affection. Though usually spoken of as General Paralysis of the insane, it is in the ordinary acceptance of the term really a nervous disease, and the slightest experience at a General Hospital in Europe or one for nervous diseases where it is very frequent will convince the observer that it is not necessarily attended by obvious mental symptoms, and that these in the very large proportion are not of a character such as to necessitate the sufferers from it being secluded in an asylum; nor on the other hand, when such is the case, are these symptoms, in the majority, of the nature of the grandiose delusions supposed popularly to be so characteristic of the disease. Indeed, the only uniform symptom is a progressive bodily and mental enfeeblement. The malady which according to some is a meningo-encephalitis with secondary degeneration of the neurons, and according to others a primary neuronie degeneration with secondary vascular changes is attended p. m. with an atrophied brain structure most obvious in the Rolandic and frontal areas, with thickened and adherent pia arachnoid, together with blood clots *in various stages of absorption and organisation in the subdural spaces*; a general pachymeningitis hæmorrhagica, with an excess of ventricular fluid and a granular condition of the ependyma, especially of the 4th ventricle.

Microscopically, there is a degeneration of the walls of the cortical arterioles which show a thickened intima, together with a nuclear proliferation of the perivascular spaces and an increase in the number of glia cells, as well as a degeneration of the cortical pyramidal and a coincident degeneration of the fine medullary fibres of the convolutions, these changes being especially evident near the areas of thickened and inflamed superjacent pia arachnoid.

General Paralysis is a disease of adult life more common in men of 35 to 50 than women. From the fact that it is believed that Tabes Dorsalis and General Paralysis of the insane are identical diseases, the difference being only in the relative place of affection, the cord in the one and the cortex in the other malady, and from the notorious fact that a history of previous syphilis about 12 or 15 years antecedent is found in most, together with the almost invariable symptom of an Argyll Robertson pupil, as well as the fact that a juvenile variety of the disease (G. P. I.), with exactly the same symptoms, is found (always in subjects of hereditary

syphilis), and that sufferers from Dementia Paralytica cannot be inoculated with syphilis and that signs of syphilitic disease are usually found *post mortem*, it is widely believed and asserted that the disease is a para-syphilitic infection, that its essential cause is syphilis, though others would add to its possible factors, alcoholism and sexual excess, and yet others suppose that its immediate excitant is a cerebral injury or sunstroke or some acute mental worry or such anxiety acting on persons previously affected with syphilis. But, on the other hand, it is not found in some races such as natives of India (nor I understand in China and the West Indies) where syphilis, certainly in India, though not frequent, is seen; also as far as can be ascertained only about 2 per cent. of syphilised persons do develop it, and as certainly anti-syphilitic treatment is not of the slightest benefit to those afflicted with it, it would seem that though in all probability syphilitic infection is a necessary antecedent, some other factor not yet discovered is required to produce it.

Recently Dr. Ford Robertson has claimed this to be a diptheroid bacillus, but the matter is still under discussion.

Sexual excess certainly will not cause the disease. Alcoholism *per se* is also not a cause, nor is lead poisoning, though both may produce a clinical entity much resembling it, and in this particular it may be worth mentioning that both alcoholism and sexual excess are often early symptoms as a result of the loss of self-control.

It is essentially a disease of civilisation unknown among savages. Though most common in men, it is found in women, and more frequently so the lower one descends the social scale; nearly all the sufferers will be found to have been people of dissipated habits, though of whatever social grade, it will always be noticed that the patient is stated by his friends to have been distinguished, more able, more quick, energetic, among his equals in position. Unlike ordinary insanity, it does not necessarily require a nervous family history for its production. In the juvenile variety met with about the age of 15 to 19, girls are as often effected as boys. Essentially the malady is a progressive bodily and mental failure, due to brain disease, the physical symptoms being the cardinal ones and those on which the diagnosis must be based. There are the Argyll Robertson pupil and inequality of the pupils plus very often loss of the sympathetic reflex. An alteration in the knee-jerks (usually these being exaggerated, but if

tabes is present, being of course lost), muscular tremor of the body first seen in the face which from an early period becomes curiously flattened, expressionless and immobile, mask-like, with a greasy skin. Immediately, however, on an effort being made to speak or to protrude the tongue, fine tremors will be noticed in the facial muscles, with a twitching of the frontalis and a fine tremor of the tongue.

The articulation is absolutely typical, and once heard, can never be forgotten ; it can only be described as consisting of slurred and clipped words and can be easily accentuated if the patient be made to repeat some test words, such as, Irish Constabulary, Artillery Commentary, and the like, which require an effort at co-ordination. It is markedly increased after any of the convulsions that are such typical occurrences of the disease.

The gait varies ; if there is tabes, it is obviously ataxic, and even if normal at first, the patient always later on becomes unsteady and progressively weaker, just as there is always sooner or later a progressive motor weakness in all the muscles of the body that culminates in complete helplessness.

Convulsive seizures of an apoplectiform or epileptiform nature are very common ; sometimes they are preceded for a few hours by a rise in temperature, and at others they are, especially if repeated and a condition of status epilepticus is produced, attended with hyperpyrexia. Retention of urine is common, and later, the patient loses all control of the sphincters, and ultimately lapses into a condition of general paralytic helplessness, wet and dirty, unable to articulate or swallow, with bedsores of a trophic nature and rapid onset.

A tendency to fragility of the bones is often noticed and is of importance in regard to nursing as well as to the possibility of false accusations of ill-treatment having caused the fracture. Mentally the patient is either maniacal, melancholic or simply demented ; a special spinal form with dementia is also described, and some rare instances of stuporose and delusional cases have also been recorded.

The form associated in the popular mind with the disease is the exalted variety in which the patient has ideas of untold wealth and power, believes that he has mountains of gold, etc., and acting on his beliefs, buys 100 horses at once, several mansions, dozens of watches, in fact, everything that he sees ; writes cheques for enormous amounts that he does not possess ; declares that he is

the strongest, ablest, finest man that ever lived, that he is a King or God himself, while to this a condition of acute furious mania is sometimes added.

On the other hand, and perhaps quite as often he may be melancholic and depressed, hypochondriacal, with failing memory and judgment, believes that his body is decaying, that he has some mortal malady and must refuse food, etc. This, it may be added, is practically the only variety in which hallucinations are ever noticed.

All varieties are attended from the first by a dementia that is steadily though it may be slowly progressive, but in the demented variety the weakness of intellect is the only mental symptom, and it is perhaps the commonest variety.

The patient will be noticed to be forgetful, a little foolish, unable to follow his occupations, steadily loses his self-control, is emotional; ultimately he becomes absolutely incapacitated for anything, and progressively becomes more and more helpless, with total loss of memory, weakened bodily and mentally, until he ultimately becomes more helpless than a little child and as wet and dirty. So long as he can express himself though, and this is seen in all varieties, all will express themselves as feeling well.

In the early stages especially of this variety, in addition to the loss of memory which is an early symptom, there is sometimes noticed a tendency to immoral acts; the patient lies, steals or even makes assaults on others; exposes himself indecently; a condition which, with his altered disposition and incapacity to fulfil his former occupations, may be strikingly at variance with his usual habits. Headache is a very common symptom. The disease is absolutely incurable and is always fatal, though its duration is very variable, most often death occurring under the second year, but he may last three or rarely longer, or a period of complete remissions and apparent return to health may suddenly supervene and last six months or a year. Though usually these with most seizures are the shortest, it is not possible to say from the symptoms which variety is likely to be of long duration. Premonitory symptoms are very uncertain and variable, perhaps the most usual being the altered habits, the failing memory followed by the "thick," curious speech, a difficulty in writing, sometimes a tendency to fall asleep at all hours, and the fact that the smallest quantity of alcohol will produce violent drunkenness.

The disease may be quite unsuspected until a sudden convul-

sion supervenes or a series of the same or a transitory deafness, blindness or an attack of aphasia necessitates a medical examination. Then and at any stage, the diagnosis can only be made from the existence of physical symptoms.

The disease is usually divided into three stages, though the steady bodily and mental deterioration is evident in all. The first is usually described as that of slight incapacity for occupation, muscular tremors, commencing affections of speech, and the mental symptoms of exaltation, depression or simply dementia, while with these there is always some loss of memory and general alteration in intellect. During this time there may be no bodily change or only a slight loss of health and strength. During the second stage the patient becomes fat and gross, his animal instincts are uncontrolled, he is very liable to convulsions, and he becomes obviously more and more weak-minded. The third and last stage is one of total mental failure, extreme muscular weakness, contraction of the limbs, loss of control over the sphincters, emaciation and formation of bedsores, loss of power of articulation, and ultimately death from some complication such as renal disease or cystitis, pneumonia, or during a convulsive seizure, or simply from heart failure. No treatment is of any avail, but careful nursing is of great service, as the patients frequently are very voracious, bolt their food and require this being minced and very carefully given to avoid the risk of choking; also retention of urine has to be attended to and the formation of bedsores guarded against. The majority of such patients need treatment in an asylum. For in the early stages, if wealthy, many will ruin themselves as a result of their delusions of vast wealth; others may commit some crime or act of immorality, and later, their feeding and general nursing can only be properly arranged for in such an institution.

The disease has to be diagnosed from (1) a form of alcoholic insanity which much resembles it, but in which there is usually no affection of the pupils and the speech is not so typical, though the presence of convulsions, mental weakness, the tremors of lips and tongue, the alterations in their jerks and gait from coincident peripheral neuritis may lead to error; but there is not the same greasiness of skin, nor the loss of facial expression as in an alcoholic; nor are convulsions so common, and hallucinations especially of a mild visual character are more usual than in general paralysis, and the alcoholic is more terrified, not so confident and boastful,

nor so given to the absurd purchasing of large numbers of the same articles as is a general paralytic; (2) Neurasthenia; (3) Ordinary mania or melancholia; (4) Paranoia; (5) Senile dementia; (6) Cerebral tumour and epilepsy. In all these the diagnosis rests on the physical symptoms and the general history of the onset and duration, but eventually on the former. Finally, some cases of cerebral syphilis may be confused with it, but such usually show more persistent headache and usually have some cranial nerve palsies, and the onset is generally at a more early period after the syphilitic infection, and there is frequently optic neuritis which is rare in general paralysis, though optic atrophy (primary) is often seen.

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## CHAPTER XVII.

### INFECTION AND EXHAUSTION PSYCHOSIS.

#### *Insanity connected with Fever and Exhaustion.*

Nearly every "fever" is attended with some nervous or mental disturbance which may vary from mere irritability, restlessness, and insomnia to delirium and semi-unconsciousness; this is well seen in any of the exanthemata and pneumonia and septicæmia, while severe malaria gives us endless examples in this country. Personally, I am inclined to say that any prolonged rise of temperature produces this result in a person of neurotic heredity or of alcoholic habits.

The delirium of the fever in such people may also pass into mania, and this is relatively more frequent in small-pox, scarlet fever and pneumonia, while on the other hand before the delirium quite subsides, or immediately after the fever and bearing no relation to the high temperature, insanity may supervene, and also as a result of the fever, after it a temporary or permanent weak-mindedness may be seen, a result especially frequent among natives of this country after prolonged malaria. Such cases are, however, only seen in people of neurotic inheritance, perhaps those of alcoholic habit excepted, and bear a direct relation to the amount or rather the deficiency of food given.

It is an open question whether these varieties of insanity are produced by a toxin of the micro-organism producing the disease or by an autotoxin produced in the body.

Clinically we may separate (1) the ordinary delirium of the fever coincident and in ratio with its severity and (2) the so-called infection delirium, bearing no relation to the temperature.

Such cases occur as the initial delirium of typhoid or small-pox, malaria and plague. The type most often seen is a condition of great excitement, sudden impulsive movements, and hallucinations, chiefly of hearing and sight. They hear people cursing them, friends and relations speaking, see persons around them who are not there. They have foolish delusions of a fleeting, silly, disconnected character; usually such patients are either dazed or giddy or seem stupefied, understanding what is said to them imperfectly, and often they are disoriented, having no idea where they are or who are around them. There are at the same time evidences of an acute disease being present in the raised temperature, the rapid pulse, the furred tongue, with sordes on lips and teeth, and general prostration. Food is usually refused. It is this delirium in which people are often sent to an asylum; the onset is sudden, the duration short, usually clearing up when the true character of the disease becomes obvious. The variety seen in commencing typhoid is often fatal.

(3) Then there is the form of post-febrile insanity occurring towards the end of a fever and sometimes separated from it by a few days' interval, forming in fact, then, one of the sequelæ of it. It is seen most frequently here after pneumonia, erysipelas and septic poisoning and small-pox, and in other countries in addition after rheumatism, diphtheria. It is naturally of sudden onset. (This form is quite indistinguishable clinically from the exhaustion psychosis to be described later.)

There is great restlessness, the patients seem anxious and disturbed, do not recognise what is said to them nor who are around them, and have no idea where they are; they declare that faces of people appear to them, that birds and insects fly about, that they are persecuted and about to die, the speech becomes later confused and incoherent. In other words, they are disoriented, consciousness is clouded and they have hallucinations of hearing, and of sight, with vague delusions. In addition they are very obstinate, resist any attempt at caring for them or feeding them, sleep is totally absent, and desire for food *nil*. They rapidly lose flesh, and persistent restlessness is a constant feature throughout.

After persisting for six weeks or two months (in rare cases for several months), such cases usually recover; what usually happens



being that all the active symptoms of restlessness, disorientation and hallucinations disappear comparatively early, the speech becomes more sensible, while the delusions (especially if, as sometimes happens, these are of possessing wealth and good fortune) continue for a little longer, but with improved appetite and increased weight these also go. This feature is particularly seen in persons of alcoholic habits, and in these cases the patients have a very limited recollections of the events of their illness, especially of its duration.

The treatment is essentially one of careful nursing and the administration at short intervals of large quantities of nourishing food.

(4) After a fever a very prolonged, sometimes permanent, period of mental weakness may follow. In all cases of convalescence from an acute disease, attended with high temperature, there is a period during which the patient is dull, heavy, has no energy, and is very susceptible to fatigue; finds it difficult to reason over things clearly, "collect their thoughts" as they say; but in these under discussion all this is immensely intensified. Such a condition is frequently seen in India after small-pox, after a severe and continuous attack of malaria, after plague, less often after typhoid. The patients are very dull, fatuous; they sit about all day doing nothing, smiling foolishly when spoken to, are often half-naked, and in many cases have no care for cleanliness and personal appearances; have no initiative, never speak unless addressed, but then answer scantily, foolishly, and after an interval, and by their replies show that they do not remember how long they have been there nor any event of recent occurrence; and also, what is more striking, that they have no clear idea of where they are or what are their surroundings. They are never resistant or obstinate. This condition may continue indefinitely, but in the large majority, by forced feeding and careful nursing they recover very slowly and gradually. A more rapid return of bodily strength and obesity without any mental improvement is of bad import. It must always be remembered that, like all cases of insanity connected with exhaustion, such patients are extremely susceptible to fatigue. They must be kept quiet, undisturbed and unannoyed. If they are obliged to work or to write, or are allowed to be excited by visitors, etc., an attack of restlessness and excitement with foolish chattering is very likely to follow, and the duration of the disease may be indefinitely prolonged. Even after apparent

recovery it will be noticed by those in immediate attendance on such people that the memory is never so good as before the attack.

(5) A fever, it must also be remembered, may appear to be the immediate exciting cause of any of the ordinary forms of insanity.

### EXHAUSTION PSYCHOSIS.

#### *Acute Hallucinatory Insanity, Acute Confusional Insanity, Meynert's Amentia*

Are all names of a very definite condition supervening in extreme bodily exhaustion in a subject predisposed to insanity by neurotic inheritance and almost certainly only seen in such. It cannot practically be separated from some forms of mental disease seen in close connection with exanthemata and other fevers. As in Europe, it may be seen here occurring after exhausting diseases, exanthemata, especially typhoid, or during the convalescence from influenza. It may follow a great loss of blood as after childbirth and the severe anæmia produced thereby, or even an exhausting attack of diarrhoea or cholera, especially if this has been coincident with forced exertion and insufficient food, and it has been occasionally seen after a surgical operation; presumably also in this case from the loss of blood, though it has been suggested that the anæsthetic in these cases may have been the causal agent. (This is not the type of insanity that follows a great mental shock, that being usually acute dementia or acute delirious mania.)

This disease is characterised by its rapid onset, short course, usually ending in complete cure under treatment by its loss of memory for the time of the illness, mental confusion, motor restlessness, complete disorientation.

The first thing noticed is that a patient, after one of the conditions above mentioned, does not sleep, and this is a prominent symptom throughout, and just as usually after this all the other symptoms commence very suddenly, so after treatment, from a deep sleep, the patient will awake almost himself again. Following the insomnia, the patient becomes restless, seems stupid, does not recognise those about him, and soon has no idea where he is, or of time, or indeed of anything around him, and his memory for passing events is practically *nil*. His attention is so defective that, if spoken to, instead of answering, he stares vacantly about him and

acts as though in a dream. Sometimes the motor restlessness becomes very great ; he crawls in and out of bed, snatches and tears the blankets and is always in movement, though of a feeble purposeless character. Other patients, on the other hand, lie smiling, foolishly crooning to themselves, rolling slowly to and fro, or weeping without a cause, and a peculiar tendency to change from laughter to tears without obvious cause will be noticed. All complain of numerous hallucinations ; they see insects, animals flying about, men's faces appear to them, the walls and articles about are distorted by illusions into faces and animals, they hear men speaking to them, smell fire, bad odour, believe that they are charmed or poisoned, or that something has happened to them.

With all this there is usually constipation, total refusal of food, a rapid, feeble pulse and bodily wasting, but no rise of temperature.

Feed such patients regularly at frequent intervals with large quantities of nourishing food, keep them warm in any well-ventilated room away from noise or disturbance, protect them from injuring themselves, give a purgative and perhaps a harmless sedative, and after a week or ten days they will one-day fall into a prolonged sleep and awake apparently well. They are, however, in a very feeble, exhausted condition, requiring a prolonged continuation of careful nursing and feeding and rest, and avoidance of all irritation, for too such people are extremely rapidly fatigued, and if allowed to see relatives, to write letters, etc., all the symptoms may recommence. Frequently much irritability persists for some time and often the memory continues for years (if not always) not to be so good as formerly. In some the recovery, instead of being sudden, is gradual, and in this country perhaps the majority of natives are of this type. They become less restless, seem to understand day by day better what is said to them and to realise gradually their surroundings. The hallucinations and delusions gradually fade and the patient is left convalescent, but with the same tendency, as in the others, to fatigue and irritability which with a difficulty in sleeping properly may continue for a long period. With persistent treatment, chiefly consisting of good feeding, a complete recovery can be expected. The time spent in the acute portion of the illness is usually a permanent blank, no recollection of it remaining afterwards.

## CHAPTER XVIII.

## INSANITY FROM THE ABUSE OF DRUGS.

It has been stated that all nations have some drug whose habitual use leads to dangerous consequences to health and that almost always these have been used first for medicinal purposes and later have been continued from the fascination produced by their stimulating properties. In this country *par excellence* these are opium and the so-called Indian hemp, *Cannabis Indica*, while in Europe it is of course alcohol. Many drugs produce mental symptoms, but clinically those believed to have a relation to insanity in addition to these, three, are cocaine, and lead; practically these are the only ones capable of being used as chronic poisons, though could chloroform, santonin, atropine, dhatura and carbonic acid be used for any length of time, no doubt we should soon have examples of mental disease from these also instead of, as at present, their interest being restricted to forensic medicine.

## OPIUM AND MORPHIA.

These have been taken first because it is my deliberate opinion that opium *per se* never directly causes insanity. It is true that this drug has occasionally, very occasionally been assigned as a cause in the statement of particulars sent with a newly admitted patient, but the habit has been always found to be a slight addition to various other causes in themselves well recognised as being sufficient for the purpose, or a short observation has proved the more potent existence of congenital epilepsy or imbecility. In the Punjab, opium-eating is such a widespread habit that had it any direct power of causation, it is incredible that some cases should not have come under observation, whereas in all my experience, and it has now been very considerable both as to the use of this drug and as to insanity in the province, no single clearly established case has come under my notice, and I can most confidently assert that its use has no permanent mental effect in the ordinary sense of the word whatsoever. Taken in small doses, it does not the slightest harm, and unless the large number of its users wilfully deceive themselves, it often gives bodily comfort and relief. In large doses it may produce defective assimilation in digestion and so be associated with general bodily wasting, but where its harmful effect is really shown is that, like all drug excess, it produces a

moral change and a social one. Quite apart from the fact that a person once thoroughly addicted to opium cannot give it up without a gradual diminution of the dose, its absolute cessation, if sudden, producing, if the usual doses are large, great depression and even alarming symptoms of heart failure, etc.\* It is obvious that a man, for several hours daily fuddled with opium, is incapable and useless, but besides that such a man becomes selfish, neglects his duties, wastes his time, squanders his substance to procure it, is oblivious of the needs of his family and the calls of duty, and in this way, as a secondary effect, it produces want, misery and destitution, and so in a person predisposed by heredity, might conceivably be a secondary cause of insanity, but such cases are rare here, and candour compels me to deliberately assert after full reflection and long experience that the accounts of the bad physical and mental effects of this drug have been most unjustifiably exaggerated.

In regard to morphia, the abuse of which is fairly frequent among well-to-do Europeans, there is undoubtedly a definite train of symptoms, but it is questionable whether such can be termed insanity, though equally undoubtedly segregation in an asylum and the consequent deprivation of the drug is the most efficient means of treatment in such cases.

Morphinism from the comparative costliness of the material is rare among natives of India, though when met with, its effects are the same, of course, as elsewhere. Rarely is it taken from pure viciousness for the sake of the feeling of exhilaration, increased mental vigour and power each dose produces, the history usually being that it has been first administered by a medical man for the relief of some painful malady. The instantaneous and great relief that it affords appeals to a weak nature, while such are unable to support the depression and uneasiness that results from its effects wearing off, and it is continued always in increasing doses, for as with all drugs a certain amount of habituation results. Gradually the unfortunate patient becomes a slave to it, so much so that the mere postponement of his usual dose is attended with feelings of intense discomfort, general hyperæsthesia, restlessness, irritability and yawning. Like the abuse of opium, its most

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\* One man admitted here maniacal and filthy was said to have become so from the use of opium, but he made a rapid and uninterrupted recovery on being given the drug, and it was obvious that his symptoms were much more due to its deprivation.

marked effect is a moral change, the habitué is a slave to his habit, he will resort to any means, any degradation, will lie, steal, fawn and scheme to obtain the drug,—curiously, such people are always liars. They will conceal and deny the habit or the amount of the dose and indeed become untruthful on every subject connected with it, and otherwise too become altered, morally. Each is selfish, fault finding, believes or rather asserts that people are against him, doubts the words and acts of relations and friends, loses all his finer perceptions, is incapable of feeling for others. However refined and good his nature may have been before, he now becomes careless, in dress and appearance, fussy, restless, talkative, capricious, exacting and utterly unlike his former self, neglecting his duties, careless of home and family, losing his affection for those near him, always obstinate and difficult to deal with and troublesome, sleepy and dull all day, gradually becoming more restless and fussy as evening and night draws on, for insomnia at that time is a marked feature.

As the effect of each dose wears off, he suffers from apathy, fatigue and general malaise, he resorts to another injection, and naturally this passes away and is replaced by a feeling of vigour and well-being, so that such patients are always either stupidly depressed or nervously excited. If the patient attempts to lessen or relinquish his habit, a dreadful feeling of depression and exhaustion ensues with yawning and often vomiting, a peculiar feeling of tickling or hyperæsthesia annoys him, constant sneezing worries him, and if he cannot obtain the drug, he may become semi-delirious or syncopal. In chronic morphia takers attacks of irregular tachycardia are sometimes met with and persistent vomiting is very frequent. Such people early lose sexual desire and power, and females suffer from amenorrhœa and are sterile. All show a general failure of nutrition and suffer from constipation, their skin is flabby and dry, there are curious anomalous affections of the pulse and heart's action, with a marked loss of energy. Even with large and continuous doses the effect is very variable; in some a rapid failure of nutrition follows and death results in a short period from exhaustion, but in quite a large number, and these will always be found to be people of marked neurotic or tubercular family history, years of indulgence in the habit often in enormous doses (30 grains daily is not at all uncommon), with all its consequent moral deterioration, may yet

be accompanied by fair bodily nourishment and fair apparent health. In such though, there is always liability to attacks of tachycardia and vomiting. Mentally in all cases there is an incapacity for any sustained mental application, and in some few there is a gradual failure of memory and intellect. In many, alcoholic habits too are given way to sooner or later and the effects of these aid and obscure those of the morphia alone. In any obscure cases of this nature it is always as well to search for scars from the injection on the arms, although some of these people become so cunning as to inject the drug into the flanks or thighs. A crucial test, of course, is to confine such patients under rigid supervision for a few days; the "abstinence" symptoms as they are termed of exhaustion, great distress, restlessness, yawning and paræsthesia rapidly come on and cannot be concealed, but it should be always remembered that great care must be exercised for rapid collapse, and death has followed sudden total stoppage of the drug in several cases. All these symptoms may be instantly averted by a dose of morphia.

The only treatment is, of course, withdrawal of the drug either gradually or suddenly; where this is suddenly effected, there is always, as said, the possibility of heart failure to guard against, but allowing for this, it is really the best and kindest treatment, for with gradual withdrawal, *i.e.*, lessening doses, all the sufferings of abstinence are also felt and are spread over a prolonged period.

Sometimes morphia takers combine with the morphia for the sake of its anæsthetic effects cocaine or use this as a substitute. Whatever doubts may be felt as to the effects of the former producing insanity, there need be none as to the power in this respect of the latter.

#### COCAINE.

Of late years a new habit, that of cocaine taking either by mouth, or as snuff or hypodermically, has sprung up. It is, however, usually taken in conjunction with morphia and often also with alcohol, while the habit has sometimes arisen when attempts have been made to substitute cocaine for morphia with the idea of curing abuse of the latter drug. It is an expensive habit and the sufferers are consequently well-to-do and frequently medical men; it is rare in India except in the large cities where it is said to be rapidly spreading. The primary effect of cocaine is mental exhilaration with a feeling of bodily warmth and

*bien être* ; the taker becomes energetic, talkative, though soon after drowsy and stupid, or if the dose is a large one, faint and collapsed. In confirmed habitués, on the other hand, the memory seems to fail, the patient becomes as though weak-minded and incapable of continued application from being so frequently in a state of semi-exaltation and excitement. Though restless and talkative, the energy of such people is without plan or direction and they seem flighty and fitful. Like all drug takers, they in consequence neglect their ordinary duties, lose their affection and regard for their family, become indifferent to what they do and are constantly varying between a state of depression and irritability, while the effect of each dose is wearing off and exhilaration and well-being when they have just taken one. There is usually rapid loss of bodily weight and general defect of nutrition, a tremulous condition of the muscles, sunken eyes, disturbed sleep and loss of appetite ; there is often a tendency to syncope, and though the patients may be erotic, sexual power diminishes and sometimes the condition passes into what can be only described as one of acute delirium. On the other hand, occasionally in chronic "cocainism" a chronic delusional condition will appear, of which the most marked and distinctive symptoms are, the curious hallucinations of sensation, the patients complain of sand under their skin, that there is wool under their feet, that they are being pricked ; with these are often hallucinations of hearing and sight, threatening voices, moving images, as a result of which they become suspicious and develop delusions of being persecuted and ill-treated by indefinite people, or they may form delusions as to their family, believe that the wife or husband is unfaithful, etc. Such people are always suspicious and irritable, and many are extremely dangerous, carrying concealed weapons, etc., to revenge themselves for their supposed injuries. The affection is of very rapid growth and becomes increased with each dose of cocaine. The only treatment is complete withdrawal of the drug, and this, which is rarely followed by some faintness and uneasiness, can only be properly carried out when the patient is under confinement. The delusions of persecution may, however, persist when the patient seems otherwise recovered, and most people unfortunately in any case subsequently revert to the habit.

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## LEAD INSANITY.

*Saturuism or Lead Encephalopathy.*

Lead poisoning is very rarely seen in India, for workers in this metal are rare, and water, the chief source of its poisoning abroad, is here usually drawn direct in iron and brass vessels from brick-lined wells and hardly ever stored in leaden receptacles. When such cases do occur, they are preceded by, and always their symptoms are combined with, those of the physical signs of poisoning by the metal. These consist of the blue line on the gums, the characteristic "wrist drop" palsy and that of the peronei, colic and stomatitis, while more rare are coma and convulsions, usually rapidly fatal. Mentally some of these cases closely resemble general paralysis of the insane, with emotional disturbance, restlessness, exalted ideas and tremor of the lips and tongue, but unlike that disease they rapidly recover when the supply of the poison is cut off. More usual in lead encephalopathy as it is termed is a history of sleeplessness, terrifying dreams, headache of a persistent character and visual hallucinations at night; the patient is heavy and dull, which condition changes to one of restlessness with fear and delusions of persecution and excitement; this in its turn again passing on into wild excited delirium, a preliminary itself to a furiously maniacal condition. The treatment, which is usually effectual, is removal of the poison, but yet many of these cases only partially recover and remain permanently somewhat weak-minded and apathetic, with defective memory. Those cases beginning with coma and convulsions are almost always fatal, and that rapidly; there is, however, a condition of stupor (which can be recovered from) that follows the excitement and must be distinguished from the coma. In cases of recovery the convalescence is always gradual.

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## CHAPTER XIX.

## ALCOHOLISM AS A CAUSE OF INSANITY.

Alcoholism does not form such an important factor in the causation of insanity in this country as in Europe, where it may be roughly estimated as being accountable in one way or another

for some 20%. The large majority of the natives of India are not addicted to the habit, and the Europeans resident out here are by their training-heredity and station usually also exempt from it. The number of exceptions, however, and the wide extent of the habit in other parts of the world renders the subject an important one. There are certain general characteristics of the effects of alcohol which must just be alluded to as they more or less attend all varieties of disease produced by it. Roughly speaking, wine is less pernicious than spirits or beer, good alcohol than bad, and occasional outbursts than steady and persistent soaking even if absolute drunkenness never happens. The drug acts primarily on the brain and general nervous system, liver and kidneys, though almost every organ and tissue of the body suffers as a result of its continued use.

Mentally it is popularly (and with some reason) supposed that the effects differ according to the variety of stimulant taken, spirit drinkers being said to be desperate and melancholic champagne drinkers sentimental, and beer drinkers more apathetic or easy going. Its effects certainly are more pernicious if it is of bad quality, but it is of some importance to remember: (1) that its action is much intensified if the drunkard is of a family in which nervous disease or insanity has occurred, and that such persons, in other words, those of neurotic inheritance, form the majority of the really inebriate. Alcoholic habits may indeed replace neurosis in an hereditary degenerate just as alcoholism in the patient may be followed by insanity in the child and *vice versa*; indeed, the intimate connection of the habit and nervous disease cannot be too strongly insisted on; (2) a very small amount of alcohol has rapidly a most pernicious effect on anyone who has previously suffered from an injury to the head or from sunstroke (acute drunkenness following a very small quantity) in epileptics; in the early stages of general paralysis, and in those people who have been at any time insane; (3) insanity and other neurosis is extremely frequent in the history of those we call habitual drinkers, just as the craving for drink is often in itself hereditary and is especially frequent in young people of feeble intellectual development and defective will power. There is strong ground for believing that a child conceived when either of the parents is in a state of drunkenness is usually an imbecile or idiot, and certainly alcoholism in the parent is a common factor in determining neuroses of various kinds in the offspring; (4) while the effect both of

acute "poisoning" by large doses or of chronic soaking to some extent depends on the special powers of resistance or incapacity for it in each individual, though the essential and characteristic effects of the poison are the same in all. Passing over the effects on the general organs of the body; mentally, these consist in a weakening of will power, a loss of inhibition and self-control, seen primarily in the fact that the smallest indulgence inhibits the power to resist the temptation to imbibe still further (this being, and with reason, the point most insisted on by the advocates of total abstinence). A gradual degradation of the intellectual faculties, an incapacity and distaste for work, a dulling of the moral sense and energy, and a liability for the descendants to take to drink or become affected with every form of nervous or mental disease, epilepsy or insanity. In advanced chronic alcoholism, even apart from insanity, there is an entire change in the self; the man loses his capacity for his particular calling, that is to say, that though he may perform the routine duties, he is incapable of any "fine" work or of any advancement in such. There is a general lowering of the mental tone, a lessened capacity for application, the self-control is less; the man becomes irritable, careless of dress or of neatness, loses his affection for his family, ultimately subordinates his habits, desires, welfare of himself and those connected with him to his craving to obtain drink to get which he will lie, scheme, contrive, and even rob. With this there is a bodily change, the expression of the face and eyes alters; the former becomes bloated, the latter watery; there is capillary ectasis of the cheeks, the muscles of the hands, face and tongue become tremulous, and finally, a characteristic picture is formed with these and the slow hesitating movements, the bent body and knees, the complaints of loss of appetite, of scanty and disordered sleep, the foetid breath, the morning sickness, the appearance of the foul tongue, signs of disordered digestion, of hepatic and renal disease or of peripheral neuritis, a whole which can scarcely be mistaken.

Always remembering that in the early stages of any form of mania or of general paralysis, one of the first symptoms may be excessive drinking, and that the same may be indulged in the early stages of any form of insanity to cure the sleeplessness and the depression arising from that disease, in which case the habit is a symptom and not a cause. Actual insanity can, however, follow the use of alcohol and does so in an enormous number of cases in Europe.

It may do so (1) directly from its action on the brain and nervous system or possibly as a secondary effect by its injurious action on the secretory organs of the body. (2) Indirectly by its causing loss of money and position and inability to follow the calling, etc., and so leading to loss, worry and trouble, in one predisposed by heredity (a) to insanity. The mixed action its use may have in this way is still more clearly shown when it is remembered that, on the other hand, there may be a direct neurotic inheritance. The son of a drunkard becoming one in his turn, and thus exciting insanity directly or indirectly; (b) in that some few cases are said to have followed alcoholism which has arisen in the craving of pregnancy. The different varieties of insanity produced are the following, always remembering that the ordinary acute intoxication with which we are all familiar is in itself a transitory toxic insanity, but omitting this, however, there are :—

1. *Delirium Tremens* which is undoubtedly a true insanity of short duration, most resembling an excited or motor melancholia. It is usually rapidly and completely recovered from in 6 or 10 days (one or two attacks even may be so recovered from, but should there be more than this, they are almost certain to be followed by some mental weakness).

2. The condition of chronic alcoholism may pass into chronic alcoholic insanity.

3. There may be a condition only to be termed Alcoholic Delusional Insanity from which is sometimes distinguished Alcoholic Paranoia.

4. There may be a condition of Dipsomania, or

5. The rarely seen mania *a potu*.

6. A condition may arise simulating general Paralysis.

7. There may arise gradually or as a sequence of any of the above Alcoholic Dementia.

8. There may be a special form of insanity met with in association with alcoholic peripheral neuritis, sometimes termed Korsakow's psychosis.

Of ordinary intoxication the symptoms are well known and can be seen daily anywhere. It will be particularly noted that the mental features are an increased excitability, and loss of control. Ideation is quickened, though as a necessity thought is shallow and not sustained. There is a difficulty in comprehension, in fixing attention, and as a result of the loss of higher control, speech is thick and indistinct, while the action of the muscles in walking is irregular,

equilibrium is difficult to maintain, and all finer muscular adjustments are uncertain. The whole resembles nothing so much as a transitory mild attack of mania, of which the symptoms pass off usually in a deep sleep or after a few hours. Very rarely, indeed, in predisposed persons the excitement of drunkenness may be continued into an attack of ordinary insanity. It is worth noting that also in drunkenness the normal temperament is peculiarly exaggerated and evident. The bully is more truculent and quarrelsome, the weak more foolish, and the morose individual depressed and maudlin.

Delirium Tremens may arise after a debauch, especially if no food is taken or after prolonged drinking in anyone. In the habitually intemperate it may be seen to follow some severe shock, and as also the condition may arise only when the alcohol is suddenly withdrawn and the outbreak seems to bear no certain relation to the amount of alcohol taken, but rather to any condition of impeded nutrition preceding it, this usually being an attack of gastritis with pain, loss of appetite and vomiting, it would seem that the actual excitant is rather a state of exhaustion from this cause in a person whose organs are already hardened by the abuse of alcohol. This is the more likely, as cases are sometimes seen where, after an injury or the onset of pneumonia in alcoholics, Delirium Tremens arises.

This disease either commences quite rapidly or after a day or two's sleeplessness or with perhaps disturbed dreams and a few visual hallucinations at night. The patient is in a condition of restlessness with marked muscular tremor, chiefly seen in the hands, lips and tongue; he is perpetually moving or rolling about, and he is in a state of marked apprehension and suspicion from the constant visual hallucinations which, with auditory hallucinations, and to a less extent those of the other senses form the chief symptoms he complains about, though he is also obviously clouded in his consciousness, disoriented, is unable to comprehend clearly and has no memory for recent events, cannot control thought or attention, and suffers from persistent insomnia, while all these symptoms are aggravated at night.

Such a patient is perpetually seeing vermin, insects, rats, snakes crawling about him; he hears voices jeering at him, abusing him, sees and hears devils annoying him, thinks his food is poisoned and smells of gases, while other tormentors crawl over him and bite him; as a result, he is in a state of terror, complains,

shouts, turns from one side to another, sweeps the imaginary vermin off his body, stops his ears or makes sudden rushes to attack or to revenge himself, or may even commit suicide to ease his misery. With all this his mind is confused, he is at the best only half conscious of where he is or of what he is doing, does not recognise those around him, forgets what happened a few moments before though he has full memory of everything up to his illness. He cannot fix his attention sufficiently to answer a question except perhaps in monosyllables, but lies perspiring with foul, quivering tongue, trembling lips and shaky hands, with dilated pupils, a temperature about 99, a prey to the vivid horrors of what he imagines he sees and hears around him, making from time to time violent and sudden efforts to avoid or to assault his persecutors, loathing the sight of food and often continually struggling, chattering and swearing.

As evening passes on, the symptoms become aggravated and a sleepless night of misery and fear follows.

Very rarely cases of D. T. are seen in which the fearsome hallucinations suddenly cease, and instead the patient becomes exalted, declares that he is a great personage, a Raja or Badshah, etc.; this which is known as the ambitious form of D. T. is almost always followed by permanent Dementia.

The pulse is weak and quick and there is usually rapid loss of bodily weight.

It must never be forgotten that there is almost always a great tendency to suicide or that the patient will often do suddenly some sudden, foolish, dangerous act; that they must never be left alone, and that they need constant watching and guarding. One man will suddenly jump up and commit suicide, another assault some one. Getting up suddenly to dash in a window pane under the impression that a mocking face outside is grinning at him is exceedingly frequent.

Sudden heart failure is often seen and always to be guarded against and pneumonia frequently occurs.

Give such patients food every two hours provided the stomach can digest it, in large quantities, a warm bath with a good rubbing down, and some harmless sedative, and generally in a few nights sleep supervenes and at the end of a week a cure is effected and only exhaustion bodily and mental remains. Instead, however, of D. T., an attack of ordinary mania may occur after a heavy drinking bout, or in place of the patient recovering, he may pass into a

condition of sub-acute mania or melancholia which may either eventually leave him or be continued as a chronic affection and end in Dementia. More rarely cases of D. T. become stuporose and gradually pass into a condition of coma in which they die, or perhaps more frequently than this the other symptoms may leave him, while the hallucinations of voices, accusations, sounds of police and other persecutors around him may continue for many months. Still more rarely the delusions of persecutions or of chronic poisoning (no doubt being in some relation to the chronic gastritis so often seen) may alone persist, and the case becomes one of alcoholic delusional insanity. Without D. T. cases of chronic insanity are seen which may conveniently be styled Chronic Insanity from Alcoholism. Such usually present all the ordinary symptoms and peculiarities enumerated as met with in those habitually addicted to alcohol. They usually have commenced by showing some moral perversion they are changed, no longer upright and honourable, but are mean, of a lower tone, untruthful, malicious, irritable; there is a general incapacity for working as before and a deficiency in energy. Recovery in this is possible though not usual, for the habits generally are continued in, and the predisposed patient will then be noticed to be, though coherent and often speaking fairly sensibly, to show delusions of being followed, shadowed, persecuted (such patients become exceedingly dangerous and others are also very inclined to suicide), to be in a condition of chronic suspicion; he or she thinks that people draw "plans of his inside" at night, read his thoughts, torment him with electricity, poison his food and drink with gases, etc. (ideas of poisoning are very common); that filth is mixed with all his food and water; that he hears voices accusing and abusing him; he complains of peculiar sensations on his skin as though fine wire or thread were drawn over it. Always the symptoms are worse at night.

As a result of the hallucinations and always founded on them the true condition of Alcoholic Delusional Insanity, usually of very rapid or even sudden onset, may be formed, though this may be of very varied nature. One man came under my notice who complained bitterly of the persecution he was subjected to by people coming behind him as he walked along the street and urging him to commit criminal assaults on women in front of him, and there is every gradation between such cases and those of others who declare that their thoughts are read and that invisible persecutors annoy them with telephones, wires and electricity; that everyone

around watches, threatens and jeers at them ; that they hear voices declaring that the police are after them. The delusions formed are always terrifying and evil, and are always founded on the hallucinations they suffer from. Some writers distinguish a variety under the head of alcoholic pseudo-paranoia in which, possibly as a result of the estrangement naturally caused by their habits, husbands become jealous of their wives or wives of their husbands ; they accuse them of infidelity, suspect them, and are always twisting some frivolous occurrence into a proof of the soundness of their belief : in this way they show a dent on a cushion, detect a smell in a room ; nothing is too absurd or petty to be believed. Curiously enough, though, with advanced suspicions of this nature their intellectual weakness, which is often considerable, is sufficient to render them inconsistent ; a man, while firmly believing his wife to be unfaithful, will continue to cohabit with her ; another with ideas of being poisoned by her will fail to be re-assured by the most obvious fallacy in his arguments. Like all Chronic Alcoholics, such patients are morally deficient ; they are indifferent to their own true interests and have no regard for their family ; all show an irritability unusual to them in former times ; they are all depressed, and often this feeling is the cause of their indulging still more in stimulants for the purpose of relieving it. Coherent and sensible as they may appear at first sight, a closer examination will always reveal in these suffering from Chronic Alcoholic Insanity though not in the pure delusional forms above referred to, a marked weakness of memory for recent events and an inability to reason clearly. Naturally, they also all show the bodily symptoms before referred to as characteristic of Chronic Alcoholism (always worse in the morning and most marked during sobriety and relieved greatly by alcohol), such as the tremors of hands, lips and tongue. The hallucinations of voices that such people have being almost always of a fearsome character, may sometimes lead, especially when construed into ideas of persecution, to the perpetration of frightful crimes, and few men are more dangerous or so actively suicidal as sufferers from these complaints.

A very clearly defined variety of alcoholic insanity is that met with in relation to peripheral neuritis and sometimes described as Korsakow's psychosis. In this disease, apart from the "physical" symptoms of paralysis, partial anæsthesia with acute tenderness of the muscles to pressure and the loss of knee jerks, there is often a sudden onset of confusion, anxious restlessness, disorien-



tation, a few hallucinations of vision and characteristic fabrications of memory. The patient is confused, does not know clearly where he is, and has absolutely no memory for recent events; he forgets an hour later having had a meal, or that he has seen you ten minutes before or anything which he has just done; but, what is very striking, he or she will give you a long, detailed account in a placid, most convincing manner of something that never happened; a patient confined helpless in bed for a week will detail a circumstantial account of a visit to a city and the people he met the day before. Others describe people visiting them, who do not exist. Women have extremely frequently a delusion that a baby is in bed with them, a most striking and common idea only met with in this affection. Many of these cases, especially with this symptom, end fatally from heart failure and in many others the defect of memory is very persistent; usually convalescence is protracted by insomnia, defective assimilation and poor general health, while, like all alcoholics, such patients are easily made irritable and are "emotional" from defective control.

Once seen, a patient with this disease is quite unmistakable, though it may possibly be confounded with similar symptoms (but then there is no fabrication) met with in general Paralysis of the insane. In this, however, the onset is more gradual than in the Alcoholic form, and there is the loss of pupil reaction and the affection of speech. A form of Senile confusion in Senile dementia is also seen, which may resemble it, but it commences also gradually and the patient is foolish, egotistical, while alcoholics are clearer and indeed show a marked gravity and conviction in the manner in which they relate their untrue experiences.

Chronic Alcoholism, especially the variety following the use of absinth, is said to be sometimes attended by alcoholic (*sic*) convulsions, but though met with, the association is not common in this country (with the exceptions those seen have shown no difference in any particulars); restlessness is not such a marked feature in these cases as in the acute alcoholic insanity (of D.T.), but sleep is almost always very deficient; and just as the muscles of the lips are tremulous in movement, so is speech often hesitatory and thick, appetite is always poor, and the taste is often perverted. Such cases may continue for many years in this condition. Perhaps the most common course is for the condition of typical chronic Alcoholic Insanity to gradually drift into one of Demen-

tia—if it is not prematurely brought to a close by one of the incidental diseases also associated with this habit.

9. Alcoholic Dementia is elsewhere described as a variety of Dementia and need not be here rediscussed beyond again pointing out that its most predominant symptoms are the marked loss of memory combined with the bodily symptoms and changes characteristic of chronic alcoholism. It is curious that when the loss of memory becomes marked, usually the desire for drink ceases coincidentally.

10. Mania *a potu* is a short but very acute condition of mania which sometimes (as though only an exaggeration of mild drunkenness) is seen in young people usually of nervous heredity after even a comparatively small amount of alcohol; with these exceptions it presents nothing absolutely characteristic and is essentially a mild transitory mania of short duration, dependent on alcoholic poisoning; it closely resembles the transitory maniacal excitement seen in hemp intoxication or the epileptic furor. There is not the same degree of prostration and bodily weakness seen in D. T., for, unlike these people, the man with mania *a potu* looks in good health, and very rarely has any hallucinations. Such a patient is exalted, boastful, quarrels with everyone around him, and homicidal assaults are not at all infrequent. Recovery under seclusion and treatment is usually rapid.

Dipsomania is a typical example of defective inhibition (impulsive insanity) as it is an uncontrollable desire to drink which seizes the unfortunate sufferer from time to time, though in the intervals the man may show an absolute loathing for all alcohol; but after a certain period—it may be several months—a state of restlessness sets in, the desire begins and “against his will,” as he may describe it, he is filled with an overpowering craving for stimulants and gives way to an orgie which may last for several days or weeks. During this time he drinks constantly and continually; everything—his pride, self-interest, his love for his family, wife and children—is forgotten; he goes from place to place, will do anything to obtain his desire; he is totally altered, is excitable, irritable, reckless and extravagant. Finally, the storm seems to wear itself out and he returns a shattered wreck to his condition of remorse and loathing characteristic of the normal period, such, however, usually becoming shorter and shorter and the drinking bouts more and more frequent and prolonged; and if some inter-

current disease does not carry him off, he lapses into a condition of Chronic Alcoholism and finally into weakmindedness.

From the tendency for this disease at the first to appear only after long intervals, such patients are sometimes popularly spoken of as quarterly toppers.

The disease is almost peculiar to people of strongly marked neurotic heredity and in such may sometimes commence in early youth. It is practically, despite all that may be said to the contrary, incurable.

The most rational treatment, although almost impossible, is seclusion, with the administration of strong sedatives when the premonitory restlessness appears. The disease is in some cases acquired by direct inheritance; a dipsomaniac may have a son who exhibits the same affection; it is said to occasionally be seen after recovery from some other variety of insanity, and in those rare cases in which it arises in persons not predisposed to it, it will usually be seen to appear later (about the age of 30) than in the typical cases.

#### INSANITY FOLLOWING THE USE OF INDIAN HEMP.

There is a special form of mental disease met with in India usually classed as a Toxic Insanity, which seems to have a direct relation to the excessive use of hemp drugs in any form. This insanity is particularly prevalent in the Punjab where the use of these drugs is very common.

It has a definite train of symptoms of a fairly uniform character; there is in the majority of those affected no hereditary history of insanity, nervous disease or tubercle; the sufferers are men of every age (I have never heard of a woman addicted to this habit); many, indeed most, are of good physique, without any bodily peculiarity or abnormality. A history of moral exciting cause is usually wanting, and indeed the only invariable element is the history of this habit, and the cases usually present so much uniformity as to give a reasonable certainty that they show a definite effect following a definite cause. The symptoms are almost entirely mental. Unlike the results of arsenic, alcohol, etc., these hemp cases never show any affection of the optic nerve, multiple neuritis or other concomitants such as would enable one to place them in the same category with cases of toxic insanity observed in Europe.

Hemp is a plant cultivated largely throughout India and Central Asia, also in the Punjab, especially in the hills, where it may be seen growing wild anywhere at the commencement of the hot weather. It is not, as has been erroneously stated, synonymous with the growth from which hemp rope is made, this latter being a leguminous plant.

As is well known, hemp is used in three chief forms; bhang, ganja and charas, though there are numerous other designations for different forms of intoxicants made from the same plant.

Ganja consists of the plant itself, stem, leaves and flowers, matted together in long bundles. In other words, it is the dried flowering top of the cultivated female plant which has become coated with resin in consequence of having been unable to set seeds freely.

Bhang is a mixture of the leaves and capsules without stems, while charas is the resinous exudation from the leaves and flowers, the method of manufacture of which is so primitive as to be worthy of mention. The cut female heads having been dried for 24 hours, each handful is rubbed between the palms; the product scraped off is charas; similar other methods for obtaining this adherent juice are in use, but each involves the same admixture of a large amount of human perspiration.

Ganja is the variety used (as is charas) for smoking in chil-lums, the native substitute for a pipe, and is then usually mixed with tobacco; its retail price is said to be 20 rupees a seer, but this, I imagine, must be an error. It is the variety most commonly used in Bengal.

Bhang is made into a decoction and drank, often mixed in various ways. It is the cheapest form, and I am told is to be purchased at 3 to 4 annas a seer. It is in this form that the Sikhs take the drug.

Charas is the most concentrated form and is either smoked or swallowed whole; its price is said to be from 40 rupees a seer, but as a matter of fact it is always purchased by the consumers in minute quantities, a few pice worth at a time.

Thandai, Sadhai, Sabzi and Patti are local names for various mixtures, generally decoctions, though this does not by any means exhaust the list of beverages in use, all containing hemp as a basis.

A certain amount of "Bhang" is used by the general population as a "cooling" drink in summer, and being thus taken in weak solution is quite harmless, but the invariable effect of these

drugs in any excess or for long continued periods is a most pernicious one, as is clearly seen in those men who resort to it as a form of dissipation and take one or other in gradually increasing doses. It is this habit which is rightly considered among natives as so disgraceful and which produces the evil effects so generally attributed to this plant.

The much-spoken-of Haschisch or the Arabian preparation of hemp is analogous to charas. Like all the others, it is the product of the dried flowering tops of the female plant, the *Cannabis Sativa* (*Cannabinaceæ*) the active principle of which, according to Lauder Brunton, is a resinoid substance, Cannabin, the tops also containing a small amount of volatile oil.

The ordinary Sikh will of course have nothing to do with either ganja or charas, both of which involve the use of a chillum. But the last-named drug is very largely consumed by "faqirs" and many of the sufferers met with here ascribe the origin of their habit to association with these men, notwithstanding which, curiously enough, it would be difficult to find any general reprobation among the native population for either of these classes, though perhaps correctly they regard the remainder of the consumers as standing on a different footing, these latter being weak, dissipated men who have taken up the habit from idleness and viciousness and who are rightly looked upon by all as belonging to one of the two classes of the weak or the vicious.

There is, on the other hand, a tendency among them to excuse in the commencement a man who has taken to the "charas habit" on the ground that he will "probably turn faqir", only another proof that the indulgence is common to, and condoned in, members of this latter class. As a matter of fact, it is almost invariable among them and accounts for the very prevalent opinion among observers that many of these men are insane.

As regards the attraction and inducement to this form of indulgence, considerable pains have been taken here to enquire from all capable of an explanation as to the habit, and by comparing the statements, a description has been obtained which, though rather vague, is so uniform as to leave little doubt that it represents the general native opinion.

In the first place, it is universally believed that the habit has a great advantage over that of opium or alcohol, or even tobacco taking, in that it may be at any time relinquished without difficulty, and though this may not be absolutely true, yet one can testify

that no ill effects follow its sudden forcible stoppage against the will of the patient. Yet there is also little doubt that any form of the drug does produce a violent craving for it, and the amount taken is (gradually it is true) increased, and that, apart from the physical effect, a general moral deterioration, as in alcoholism, sooner or later sets in, so that, as is well known, an habitual charas eater will spend his last pice on the drug in preference to buying himself or family food or clothing.

In the Sikh Temples "bhanga" is taken much after the fashion of punch in times gone by, *i.e.*, from a common bowl by many men in company, and one often sees at any festival a large iron vessel full of it exposed for public consumption. It is, I believe, rare to find a solitary drinker either of that or indeed of any of the hemp drugs; even those men who stated to me that they brought their own supply always added that they took it in company, and it is a notorious fact that there are certain seats, *takias*, literally a cushion or faqir's wooden seat in large towns such as Lahore where these very men congregate for this purpose; and though men such as prisoners under special conditions take "charas" in the form of pills when alone, all natives assert that this drug is in the Punjab usually smoked in a *chillum* with tobacco and then generally in company, very rarely alone, the *chillum* being handed round from one to the other, or as they say one man smokes it until he becomes dazed and then passes it on to another. Their motive then, they assert, is to get *aram* (ease), to make their food digest (and that for this reason it is usually smoked before a meal), to produce a sense of general well-being, etc. Curiously enough, all the smokers are mixed and not necessarily of one caste; when questioned as to quantities, they state that "one pice worth can produce" *nasha* (intoxication), but that there is a gradual habituation as usual to the drug and that the amount has to be slowly increased. Some state that one pice worth will suffice for four or five men, so that it is difficult to ascertain the exact quantity taken, and the obvious probability is that the amount varies with the habituation, and as to the relative amount of tobacco if mixed with this and taken in that manner and the market rate, etc.

Although the fact seems so extremely unlikely, it is universally stated that while bhanga, ganja, etc., are aphrodisiacs, that charas has a contrary action and that it is used for the purpose by faqirs, a qualifying statement, however, which throws the greater

doubt on its probability. Many natives, however, have assured me that the aphrodisiac powers of the drug plus its intoxicating effects is the real reason for the use of all these drugs, though all agree that faqirs take charas ostensibly for the very opposite purpose.

A very clear account of the habit was given me by one patient whose statement is a good example of that furnished by all. This man had no hereditary history of insanity, nervous disease or tubercle, and all enquiries failed to elicit any probable cause for his insanity. He was originally admitted on the 13th October 1901 for acute mania, presumably due to hemp drug, and was discharged cured on the 11th April 1902. He obtained work in Lahore as a brass-worker, and for a time did well and remained sane and abstained from charas entirely, but some family trouble of a trivial nature occurring, he again resorted to these intoxicants, and a fresh attack of violent mania quickly followed, for which he was re-admitted. His insanity, then, had the usual characteristic of garrulity, constant laughing and talking, general incoherence, continual restlessness and reckless violence, with sleepless nights and the typical flushed face and congested conjunctiva. He was filthily dirty, indescribably so; he had a huge sloughing wound on the ankle, the accidental result of his own violence, from which he several times a day tore the dressing and filled the sore instead with fæces. However, he rapidly recovered (in about a month and remained sane for nearly a year until finally discharged in that condition). Though like all these men he had absolutely no recollection of the period of his insanity, after recovery he voluntarily described his hemp habit and attributed it to that; described how he used to take half a tola of bhang mixed with khur and sweetmeats (ostensibly to increase its intoxicating effects) and water as a sherbet. This cost him a pice at a time, half for the bhang and half for the other ingredients. This luxury he declared would suffice for two or three men to be intoxicated on, "a half tola of bhang would make *one* man very intoxicated." The motive, according to him, was to get *aram*, "to cast his thoughts on God," to make him work better, also that during the simple *nasha* or "intoxication" the men sleep or are in a state of ecstasy, that this is followed next day by headache, for which they apply *dhai* to the scalp as a remedy. He agreed that bhang and charas could be relinquished at any time, though he added that others denied this, and was very clear on the subject of bhang, "like

opium," being an aphrodisiac. He was again re-admitted on 21st April, 1905, with a similar history and symptoms, this time losing a finger from gangrene after a self-inflicted injury that he would not allow to be treated. He recovered by July 1906 and is still in the asylum, and so long as he is kept from indulgence in the drug remains sane. As in this man, so in all similar cases. The facts of the habit of indulgence in hemp drugs is usually verified by the statements of friends and relations and confessed to by the man himself after recovery. No one will dispute that there is a possibility of a man being a charas eater, and yet that his insanity may have arisen in other ways, or that the habit may be a secondary cause in one otherwise predisposed by heredity, etc., to mental disease; indeed, the very characteristic results of the habits lends probability to the assumption of this being often so, for it is seen very frequently in men of vicious dissipated habits and leads frequently to destitution, misery and many other troubles, sufficient in a predisposed man, to start insanity. It is also possible that as in the case of alcohol, charas excess may be the first symptom of loss of control in those in whom madness is commencing, but when all is said and allowed for, the history of so many cases is so extremely clear and apparently conclusive, cases when all heredity of insanity or other allied disease or other possible alternative factor seems certainly non-existent, and the association of the habit and the disease is so extremely frequent that no unprejudiced observer could avoid being convinced of its strong influence in causation, while in regard to false statements it need only be remembered that the habit is regarded as very disgraceful and is not one which would be willingly admitted; indeed, it is often studiously concealed, so that such an explanation is in the highest degree improbable. It might also be asked when this excess is so frequently given as the cause of mania among males as to why if this habit of the statements are to be regarded as erroneous, should it be never assigned either in the schedule, or by the relatives, or by the patients themselves in cases of melancholia, primary dementia, epilepsy or in any form of insanity among females; it never is.

It must be remembered that only a small proportion of the population are addicted to the use of these drugs and only some of these to excess. The Commission on the subject of 1894 went very carefully into this matter, and by a most ingenious method arrived at a conclusion which agrees with common observation and was in all probability correct, and that was that only some



0.5 per cent. of the population or more probably a quarter of this number are in any way addicted to the habit.

On the other hand, nearly 33 per cent. of the male patients in this asylum are believed to have been habitually hemp drug takers at one time or another, a relative difference which, if nothing more, is at least extremely striking. Lest this statement should be capable of misconstruction, I should like to say that it cannot of course be supposed that the cases of insanity treated here, the only Asylum in the Punjab, represents the entire amount of mental disease in this province of nearly 24 millions of people. A far greater number of helpless, harmless cases must be at large and untreated. The numbers seen here only represent the total of those so troublesome and so dangerous as to be of necessity put into seclusion. It is, however, precisely these noisy, troublesome, dangerous cases that are most often attributed to hemp excess, and proof is continually accumulating that this belief is often well founded, though I am unable to give any evidence of a contrary nature, that is to say, of any men addicted to excess of charas who have remained sane. The common native opinion is that such always become affected mentally, but this I have not yet been able to test; certainly a large dose of hemp in any form invariably causes definite symptoms to be subsequently described, and the probability is, to my own mind, that the common opinion is correct.

Since this Asylum opened on the 1st March 1900, 1,207 men and 292 women have been under treatment to the end of 1906, and of these men excess in the use of hemp drugs was alleged to be the cause of their insanity in 259. As no woman has ever been declared a victim to the habit, we may exclude the females. We may, therefore, say that of 804 cases of mania (in only two cases of melancholia have the men been declared to be in the habit of taking the drug and in these the correctness of the suspicion was more than doubtful) treated here from 1st March 1900 to 31st December 1906, in no less than 259 was this attributed to hemp drugs, and this proportion, careful enquiry from individual cases has led me to strongly believe, to be very little if at all exaggerated.

The cases of insanity attributed to hemp drug excess show a very striking uniformity of symptoms both mental and physical, and were the causation given, put down in error or at random, it is

inconceivable that other cases of mental disease totally differing should not have been frequently included.

I have also notes of several cases in which men discharged completely cured, who had owned to this habit and attributed correctly in my opinion their insanity to it, have again indulged in it to excess, and have quickly become insane, while *vice versa* others who have strictly abstained have remained sane. Of several of these men showing these contrary instances, I had most intimate knowledge and the sequence has been too exact to have at least in my opinion any ground for doubt on the subject.\*

The results of hemp drug excess may be—

Simple intoxication.

A mania transitoria.

Acute mania.

Chronic mania with delusions.

Dementia.

The immediate effects of any large dose of hemp is first dizziness followed later by excitement, delirium, hallucinations of a pleasing nature, visual and auditory, a rapid flow of ideas, a state of ecstasy, a great inclination to muscular movements with a marked tendency to acts of wilful damage and violence.

A state of recklessness and disregard for danger and consequences, the whole followed later by deep sleep and forgetfulness of all but the initial symptoms.

The history always given is that they have been induced to partake of a large amount, that they fell into a state of *nasha* (intoxication) and remember nothing more until finding themselves in custody or in the asylum; it is difficult to state the duration of the lapse of memory which is such a distinctive feature both of simple intoxication or of the acute form of mania; it is always several days and may extend to some weeks.

The most common form seen in an asylum is a condition of acute mania of short duration (as these cases usually recover rapidly when the supply of the drug is cut off), a violent mania of sudden onset with great exaltation and sense of well-being, restlessness, noisiness, intense irritation at the slightest control, a tendency to

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\* In one woman the cause was stated to have been hemp excess, but this could not be substantiated.

A very characteristic point in cases of the more chronic variety is that such people, even when otherwise apparently sane, are quite "disoriented" as to place; they have no idea where they are or whom they are surrounded by, and this is always the last symptom to pass away.

commit wilful damage and especially acts of reckless violence with physically a suffused face, bloodshot eyes, heat of scalp, etc., and always followed by complete forgetfulness of the entire period. There is no condition attended with reckless violence to at all compare with these cases, and once seen, such an instance can never be forgotten, and it is this fact which renders hemp drug insanity of such importance from a medico-legal point of view as many, very many cases of murder committed during this condition have been known; and when no opportunity of examining a patient arises, a history of sudden onset, of excitement with intense violence, resulting in a brutal unprovoked murder, with proof of administration of the drug and complete amnesia afterwards is very significant.

The hallucinations described are also very characteristic; these are almost always of female figures, frequently *devtas* visiting them at night and conversing with them, or other hallucinations of sight and hearing. It is wonderful the uniformity of the description given both in the acute variety and in the chronic form of mania that sometimes follows. Instances have repeatedly occurred here when a man, on recovery, has attributed his insanity to a single large dose of bhang or charas, generally stated to have been administered by a faqir; it then exhibits the usual symptoms characteristic of acute insanity after hemp excess and only differs in its more sudden onset and much shorter duration, so that it appears to be a mania transitoria; it is always followed by complete oblivion of the period of excitement.

It is well known that bhang was often taken, especially by Sikhs, to nerve themselves for acts such as fighting requiring dash and courage, and it is notorious equally that people intoxicated with hemp drugs are liable to commit as before said acts of homicidal violence, to run "amock" or to attack people without provocation; it is certain that acts of this kind quite unpremeditated may be performed practically unconsciously under the influence of charas, etc., and yet no recollection may remain on recovery. On the other hand, it is obvious that this property of the drug may be taken advantage of by a man to nerve himself for a deed which he has already planned—murder, etc. In those who take hemp regularly, it is a different matter. The effect of the drug, of course, may vary with the amount taken and the habituation of the taker. In its simplest form it is a condition of a mild *nasha* which is what the ordinary habitué aims at, a state

of pleasant semi-delirious rapid flow of ideas with pleasing, usually sexual, hallucinations, a condition of extasy and indifference to surroundings or rather an interpretation of them to anything most pleasant. If the dose be larger, this passing on to wild delirium, struggling recklessness and acts of violence, of all of which on awakening he has not the slightest recollection.

From a condition of this kind indulged in every day the unfortunate man, either increasing his allowance or repeating it so quickly as to leave no perceptible time for recovery from each intoxication, passes into a condition of violent mania and requires seclusion in an asylum. If the indulgence has been less in degree but more prolonged, he lapses into a condition that can only be called Chronic Mania. The very acute forms only vary in degree and duration from the pure mania transitoria alluded to, just as this also is only a variation in degree from the condition of reckless violence met with in the very acute intoxication. All the acute cases recover very rapidly and so do most of those one terms Chronic Mania, but a certain number, for reasons not very obvious, remain unchanged, and a still smaller number lapse gradually into a demented condition in which they ultimately die.

This is perhaps the place to recall that almost all writers on the effect of Cannabis Indica and especially of that form known as "Hashish" lay great stress on one very curious effect experienced during intoxication, *i.e.*, that it produces an enormous apparent prolongation of time and exaggeration of distance; during its full intoxication seconds seem hours, "a strange sensation of all seen objects being at a great distance." objects seeming as though looked at through the wrong end of a telescope, etc., etc. The descriptions are very uniform and undoubtedly correct, but one has never been able to obtain any accurate description of the same from the dull, uneducated people who form the large majority, indeed the whole of those coming under notice here.

From a diagnostic point of view I should say that a case of mania in a male in this country, with intervals of prolonged and intense excitement, great exaltation of ideas and a tendency to impulsive acts of violence and destruction in the earlier stages, with total loss of memory for this period afterwards and attended with persistent conjunctival congestion in the horizontal vessels only is extremely likely to be of toxic origin from hemp drugs, especially if it recovers rapidly and perfectly. The very acute

cases are, I consider, almost unmistakeable after one has once seen a well-marked example.

For treatment the most essential point is the absolute stoppage of all hemp drugs, while residence in an asylum, regular feeding, fresh air, exercise and some regular manual employment are very beneficial.

No drug has ever yet been found here of the slightest service whatever and that after extended trial of very many, and I am quite sure that the employment of blisters to the nape of the neck, leeches to the temples, nauseating doses of tartar emetic and saline purgatives, all formerly recommended, are now-a-days as useless as unnecessary.

The history and symptoms of the use of hemp drugs are, as is well known, alluded to in most works on Forensic Medicine, though in none are they so admirably described as in that wonderful work of Dr. Chevers, where will be found a most interesting summary. He there alludes to a symptom I have never yet met with, namely, a complete loss of speech lasting for prolonged periods after recovery from the intoxication, the patient understanding what is said and making "vain attempts to speak."

In these cases there seems to have been a form of isolated paralysis of the tongue.

Many of the old records of cases of poisoning by hemp are, however, it must be remembered, instances in which the drug was given mixed with *Dhatura*, and it is not always easy to separate the action of the two.

In the very few cases that I have been able to examine *post mortem* no changes sufficiently marked or uniform to warrant description have ever been found; almost always there appears nothing abnormal to the naked eye.

Natives of this country, however, assert that sudden death may follow a "prolonged pull" at a *chillum* of charas or ganja, and though this, one would imagine, is more than doubtful in the case of healthy men, an enormous dose of hemp may of course prove fatal.

In 1898 I saw two instances of this; in each the man was a prisoner who had been previously addicted to charas, but had perforce to relinquish the practice on confinement. Each, however, suddenly obtained possession of a considerable amount and took a larger dose than he had been in the habit of taking even before being arrested. The effect was rapid coma with vomiting of green

coloured contents of the stomach, stertorous breathing, etc., with most marked congestion of the conjunctiva and coldness of the body surface.

*Post mortem* there was a most curious acute congestion of all the internal organs of the body, forming such a strongly marked appearance as to greatly impress an observer.

Now, it is well known that *Cannabis Indica* has medicinally a powerful diuretic effect, one which probably explains its value as a combination with Bromide of Potassium ; also it is noteworthy that, as I have remarked in scores of patients, all cases of toxic insanity from hemp drugs have marked conjunctival congestion, limited often to the horizontal vessels, in recent cases these showing acute congestion and in old ones, even of many years standing, this being replaced by a well marked line of blood pigment in the same situation. This is almost always met with and is peculiar to such cases.

There is indeed little doubt that one of the effects of hemp is to act directly on the sympathetic portion of the autonomous nervous system, *Brain*, 1903, page 1, and to thus affect chiefly the blood vessels, and that its continued use causes prolonged dilatation of vessels and probably stasis in the smaller capillaries of all the internal organs, and the explanation of the common belief among natives of the country that the use of hemp predisposes to dysentery and diarrhoea lies, one might suppose, in the chronic congestion thus produced of these organs ; whether an explanation of a similar nature is applicable to its effect on the brain one cannot yet say, but that it has such an action there is not the slightest doubt.

If called in to a case of acute poisoning when partial or complete insensibility has set in, there will be found to have been vomiting of green contents of the stomach, intense coldness of the body surface, a weak pulse, slow, laboured breathing and frequently purple lips and contracted pupils (Chevers). For such the only treatment is complete and speedy evacuation of the stomach, and the use of stimulants. As an antidote, vinegar, citric, acetic and tartaric acids have been recommended, while it is worth remembering that coffee, tea and cocoa are said to increase the action of the poison.

Curiously enough, the use of *Cannabis Indica* has been advocated in England as a valuable sedative and hypnotic in insanity on account of its diuretic effects when given with bromide, when

it forms a most valuable and successful combination and one largely used both in Epilepsy and in cases of Chronic Mania, especially when these are characterised by hostile, vindictive and homicidal violence, Beran Lewis Text-book of Mental Diseases, page 483. (He, however, also states that in full doses it causes great exhilaration and a condition of reverie with a pleasurable train of mental and nervous phenomena, vivid hallucination and a stage of ecstasy followed later by sleep). \*

Reynolds used also to advocate its employment in the sleeplessness of senile insomnia and as a general hypnotic.

Even in England, however, its use is contra-indicated in the stage of acute mania and that of melancholia and depression, and personally I should hesitate long before administering it in this country when such a large percentage of the patients at any rate have been previously addicted to it, even when the medicinal doses given are so extremely minute compared to those which the habitués have been in the habit of taking. It is, however, extremely difficult to form an accurate comparison between the medicinal doses and those taken as an intoxicant, or rather it is difficult to believe the result even though the statements are practically unanimous. The best comparison is perhaps to be made with the medicinal extract and bhang (mixture of leaves and capsules without stems) of which 4 men will take 2 ounces.

(Bhang is sold at 4 annas a seer (—32 ounces), 4 men will smoke one pice worth, *i.e.*, 1/16 or 2 ounces, and this, one would imagine, equal to 0·4 ounces of the extract for 4 men, which would amount to 0·1 or 43·7 grains each, an incredible amount.)

The explanation probably lies in the fact that buying it in small quantities the men obtain less for their money.

From the 1st March 1900 to the end of 1906, 142 cases have been under treatment in this asylum for insanity due to hemp drugs out of a total of 1,207 male patients (no female case has ever yet been seen.) Of these 10 have become demented, and though

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\* In this particular Wood, who also apparently experimented on him elf, is cited as to these symptoms being followed by numbness, spells of partial unconsciousness to surroundings, an indefinite prolongation of time seconds seeming hours, an exaggeration of distance and a horrible sense of impending death with an antagonism between the feelings and the will "referred to an outside factor universal to the personality." He also notes the powerful diuretic effect of the drug and alludes to the benefit of its combination with bromide for the purpose of avoiding Bromism.

8 died, 82 recovered, while the remaining are still in a condition of chronic insanity.

Many of the cases were simply instances of intense intoxication, but it is obvious that there is every gradation between these and cases of prolonged acute mania, so that it is difficult to distinguish them, and no one with any practical experience of the furious homicidal and destructive tendencies of these patients will question the advisability of them being at once put under restraint and observation and proper treatment. Some excuse is perhaps necessary for treating the question of insanity from this drug at some length, but apart from this form of insanity being of extreme importance medico-legally, it may be here recalled that in 1894 a commission was appointed to enquire into the subject and that they failed to find any evidence of its action in this respect; the members, however, were not medical men, and though no one who has read their report can have failed to be struck with the extreme care with which the subject was gone into, equally no one with any experience in the matter and on account of the small numbers of habitués (outside an asylum) to the drug—these are not many—can fail to be firmly convinced that their conclusions were absolutely erroneous and untrustworthy.

*En passant* it may be said that in medicinal preparations one of the greatest drawbacks to its use is the extreme variation of strength found in different preparations.

Similar effects of hemp intoxication, though varying in detail, are cited by Grubbe and Hehir, p. 451, and Chevers, page 219, as having been given by Bandelairie (the latter author I have been unable to study in the original, nor have I been able to find the works of O'Shaughnessy who is also quoted in the Hemp Drugs Commission 1894 Report, Vol. I, page 198). As comparing the first intoxication of an adult with hemp to cases of Delirium Tremens and as remarking on the strange balancing gait of the patient, the constant rubbing of the hands together, the perpetual giggling, the propensity to chafe and caress the feet of bystanders of any rank and as stating (which is undoubtedly true) that the eyes have a distinctive expression of cunning and merriment, and that other patients may be violent or highly aphrodisiacal and a few voraciously hungry. Most observers also state that the urine in the case of those taking Cannabis Indica in addition to being increased is said to have a peculiar odour as of a "Tonquin bean," and generally they add that its use leaves no bad effect on digestion; this latter



is a point on which natives differ in opinion, but all are agreed that on awakening from sleep they suffer from extremely prolonged and violent headaches.

## CHAPTER XX.

### EPILEPSY AND INSANITY.

The conjunction of Epilepsy and various forms of Insanity is extremely frequent among the inmates of an Indian asylum, not that the relation is in any greater relative preponderance in the ordinary population than in that of Europe, but that the dangerous and troublesome nature of these cases leads more frequently to their detention than any other kind of mental disease. In addition to this also the cases are frequently the subject of medico-legal question and trials at law in which medical evidence is called for. Epilepsy is a disease usually of early life but not confined to that, in which at uncertain intervals whose duration it is impossible to foretell, the patient is attacked with sudden unconsciousness and convulsions. All convulsive attacks are not epileptic nor are all epileptics necessarily mentally affected, and it is not possible to state the proportion of those that are so.

“Epilepsy is the occasional sudden excessive violent discharge of some nerve centre sensory or motor.” *Broadbent Brain*, 312, 1903. All nervous actions can be most appropriately spoken of as of the nature of a discharge, explosive and chemical, “a sudden re-adjustment of molecules with liberations of energy”. In ordinary nervous action, this is orderly, its amount is limited and it is adjusted to the stimulus calling it forth, but in a convulsion there is a sudden excessive and disorderly discharge, the reaction resulting varying necessarily with the point or seat of it, most especially it is sudden and chiefly on account of that quickly spreads from its original seat to all the cells around or all over the brain. In Epilepsy there is an area of the brain in which the nutrition of the cells is modified and in which the cells are in consequence unstable, the normal explosive matter in them being in excess or deteriorated and unstable. As almost any portion of the brain may be affected, there may be almost any kind of Epilepsy. Convulsions, however, may be hysterical or may occur in uræmia, lead poisoning, in alcoholism and at the onset of a vascular cerebral lesion and other diseases, and are sometimes then spoken of as Epileptiform. But true Epilepsy may be divided into :—

1. Epilepsy from affection of some part of the brain cortex other than the Rolandic.
2. Jacksonian Epilepsy.
3. Ponto Bulbar.

In a typical Epileptic "fit" there is usually a warning, some peculiar feeling the patient has (usually called an *aura*) immediately after which there is a sudden loss of consciousness, the patient if erect falling to the ground ; there is intense pallor with a rigid (*tonic*) muscular contraction of the whole muscular system, the eyes and head being usually turned to one side, the limbs stiffened and rigid, the chest seems fixed and respiration arrested as a result of which the face, which at the commencement of the attack is often seen to turn pale, becomes first flushed and then cyanosed gradually ; the fixed tetanic muscular contraction is felt, becoming vibratory, then remittent, and finally, a stage of (clonic) spasm sets in, in which the limbs, face, head and trunk are convulsed, jerked and moved about violently, saliva turned into foam appears on the lips, the tongue is often bitten and the *fæces* and urine may be expelled. The whole duration of the fit is usually half a minute, though it of course appears much longer. With the clonic convulsions the breathing returns, the cyanosis passes off and the unconsciousness lessens ; at its termination, the patient is left semi-comatose, which condition gradually passes into stupor and this into sleep which may again be continued for a variable interval as dulness and mental confusion.

This is the major variety (the grand mal), but another minor variety (*petit mal*) is often seen of great importance if only on account of its being so often overlooked, and the true nature of the malady not recognised, while the two varieties may co-exist. In the latter there is a very fleet passing unconsciousness not accompanied by convulsions ; a patient may suddenly stop talking, eating or moving, there is an instant silence, a pallor of the face, and then the former conversation or occupation is resumed as though there had been no interruption. It must always be remembered that (1) all memory of the fits of whatever kind except of the *aura* preceding when such exists is always lost, and as some rarely, it is true, have no *aura* and other patients may have their fits only at night and may only be aware afterwards that the bed is wet or their tongues bitten, they may have no knowledge of their existence.(2) The *petit mal* frequently consists only of the *aura* (and nothing else) which in the major fit

precedes the actual unconsciousness and convulsions. (3) That after any variety of Epilepsy the patient may pass into a hysteroid convulsion, and this may be so prominent and long-continued as for long to obscure the real disease; (4) a condition of fulminating vertigo may really be a variety of Epilepsy.

2. Jacksonian Epilepsy, unlike the ordinary kind in which *post mortem* nothing may be visible with the naked eye, is that variety usually following an obvious lesion, thrombosis, tumor or syphilitic disease localised in the Rolandic convolutions. It is characterised by unilateral convulsions preceding the unconsciousness which indeed does not usually occur—it commonly starts in the thumb, index finger, the mouth muscles or great toe, some part “most employed in fine and complex movements”; it is at first limited to this, but usually spreads up the limb or part first affected and then down the others. It always begins and spreads in exactly the same manner with each fit, and it can often be prevented if a ligature can be rapidly applied round the toe or thumb, etc., in which it commences so as to produce a strong counter impression. It is frequently followed by some temporary paresis of the affected parts and is rarely attended by any of the mental changes so frequent in major Epilepsy.

3. Bulbospinal Epilepsy is seen in cases of laryngismus and certain rare cases in which a patient, usually a child, has fits of unconsciousness marked with preceding or coincident arrest of respiration and contraction of the trunk muscles. It also is not seen in conjunction with insanity.

The *aura* in the ordinary course may be of any kind and of course varies with the seat of the disease. Most rare but particularly noticeable is the uncinat variety where the warning is of some feeling relating to the digestive system, a bad smell or taste or epigastric sensation movements of smacking the lips, chewing or spitting. It is often attended with a peculiar dreamy state, a sort of double consciousness—an idea of having been in a similar condition or surroundings before, while perhaps for this latter reason sometimes too there is a sense of fear or horror. Nothing is of so much interest in an asylum as studying these *aura* in their multiform variety, for that of almost every patient is different. Some have a sense of sudden thirst, others a visual hallucination, a ball of fire which suddenly bursts the unconsciousness immediately following, some a tendency to run round and round ;

others describe the fright of seeing dogs and jackals, etc., etc., their varieties will be found to be endless.

The connection between insanity and epilepsy is a most intimate one and should never be forgotten. It is frequently met with in the family history, etc., as having occurred in the predecessor or near relation of those affected with insanity. Epileptic parents may have insane children and *vice versâ*. One sister or brother may be insane, the other epileptic and, the disease itself may be actually associated with insanity in several ways, of which the following are the chief:—

- (1) Epileptic larvée marked epilepsy and epileptic automatic acts.
- (2) Epilepsy is frequent in the idiot.
- (3) An epileptic always of fairly average sanity may become demented.
- (4) The weakmindedness and epilepsy following infantile hemiplegia.
- (5) An epileptic may become maniacal, or a maniacal condition from time to time may follow attacks of convulsions or precede them.
- (6) The post-epileptic fury.

I would here like to lay particular stress on the fact frequently forced under notice in this asylum that insanity with epilepsy may simulate almost any form of mental disease. Cases apparently of katatonia or other forms of stupor or of Dementia Præcox, melancholia and mania have been admitted and diagnosed as such until after a short observation; an epileptic convulsion has shown the error, and longer residence has clearly shown that the case was essentially one of epilepsy. It is of course not possible for any one to claim that these were instances of these diseases with epilepsy coincidentally also affecting the patient when their condition varies with the number and frequency of the attacks.

All epileptic attacks are attended with heaviness and dulness and a tendency to sleep immediately afterwards, and many have a certain amount of mental confusion following them, but in other cases, instead of awakening in a normal condition from sleep, the patient is, though able to speak, walk about, etc., only half conscious of what he is doing; he will fumble for a long period with his pyjama string, undo and do up again his coat, perform some automatic act, always the same, or in still more advanced cases,

happily not common, they will wander away as though in a somnambulistic state, while to a stranger they will appear in their senses, but after an interval which may extend to one or several days, they will awake to find themselves far away from their home or perhaps in custody for having stolen or attacked some one. These have absolutely no knowledge either of the fit or what happened later, or only remember the onset of the convulsion; but afterwards such cases obviously may give rise to legal questions and need very careful consideration. I saw once a young lady picked up half stupid and dazed on a doorstep in London—nothing could be found to account for her condition, and it was not for two days later that after falling asleep she awoke to give her name and address and to prove that she had fallen while in a fit. The cases, however, peculiarly attributed to this condition are those in which with full ability to speak, walk and act, often in a criminal manner, there is after one or two days an awakening to their natural condition; with loss of memory of the intervening period; such undoubtedly exist. A certain amount of automatism after or before a fit is, on the other hand, extremely frequent, some curious act repeated incessantly after the convulsion, or a peculiar and unvarying habit preceding it by even hours: of such there is always complete forgetfulness afterwards. One patient here always begins making up his accounts, another walks round and round in a circle, scattering on all sides his treasures of rubbish that he has amassed, others scratch some particular part of the body. Such are endless in their variety and of extreme interest in conjunction with the actual onset and progress of the fit, in point of inquiring into the exact brain area chiefly affected. In themselves, of course, they do not constitute insanity, but are most frequently seen in those obviously mentally affected.

After a fit, however, instead of the stupor and mental confusion which is a typical ending, the patient may suddenly pass into a condition of fury, of wild maniacal rage in which they will tear, rend, murder and mutilate. Such patients are, without exception, the most dangerous of all insanes, and it is in view of the possible occurrence of such events that all epileptics are to be regarded with suspicion. Such patients, even with most marked fury, accompanied with diabolical acts, have no idea afterwards what they have done. The occurrence is absolutely sudden, never to be foreseen, and never can be prevented. Another variety of

epileptic exists in whom from time to time after several fits, which then have usually occurred in quick succession, a state of less acute but still sufficiently dangerous mania takes place. The patient, perhaps a steady, good worker, is changed, restless, regardless of cleanliness or personal appearance, is unreasonable, wilful, destructive, and violent; curiously enough, in most there is a strong resemblance to drunkenness; the eyes are heavy, the speech thick, the gait a little reeling, the head half bent, the motions not accurately carried out.

Such a condition in many, too, precedes the attack or a series of attacks, and in them there is often a premonitory period sufficiently long to allow of the patient's seclusion and in which he becomes querulous, makes unfounded complaints, will not follow his usual occupations but wanders about, and is irritable and difficult to manage; this increases; a condition of angry muttering mania with violence and destructive tendencies follows, suddenly, arrested by one or several fits, after which there is a period of torpor and mental dulness and then the patient is left comparatively well and follows his usual occupations in the asylum. Such conduct undoubtedly precedes in many an outbreak of convulsions, but though it cannot be actually proved, there is strong ground for belief that it itself follows an attack of *petit mal*, and that, therefore, all such maniacal periods are in reality a consequent of preceding epilepsy.

Every gradation is seen in these epileptics in whom fits single or in groups are preceded or followed by attacks of excitement between a mere change in disposition and behaviour to outbursts of wild mania; nearly all these cases are violent, or if the outburst is of a melancholic nature, which sometimes though rarely happens, it is more of the nature of a sullen bitter brooding over supposed wrongs and persecution. Any and all of them are liable at any moment in this condition to do some wild, furious act, and none of them should be ever trusted. Some patients translate the feelings they have at the outburst of the fit (when it commences by some definite aura), or the fatigue and injury that often remain afterwards, into evidence of wrong and injury they suppose to have been inflicted on them; and the desire to revenge themselves for their supposed ill-treatment adds another to the list of those already dangerous and violent. One girl here daily cites a list of supposed injuries inflicted on her always in identically the same terms, and describes minutely the muscular contortions which she

has obviously undergone during her fits, of the occurrence of which she is totally ignorant.

Epilepsy is an extremely common cause of idiocy, and many children with this conjunction are seen. I cannot say that beyond the convulsions there is any special peculiarity noticeable; they are usually, however, of violent temper, especially when the fits are about to happen. Though there is no marked diminution in bodily stature, and the facial degradation so frequently seen in congenital idiocy is less common, many of them are, however, unable to speak and are of extremely low grade of intelligence, and all usually have marks of injury, the result of falls, and there is in the majority, curiously, a certain amount of inequality on the two sides of the skull.

There is one, however, particularly well-marked variety, namely, that in which epilepsy supervenes about the age of 8 to 12 in children suffering from results of infantile hemiplegia; all children who exhibit this affection in infancy, it may be stated broadly, invariably develop epilepsy in after-life, and the appearance of such with the slightly dragging foot, the affected face, the undeveloped limbs on the same side and contracted hand, with the marked diminution of the opposite side of the skull, forms a picture absolutely typical and impossible to mistake. The mental condition is, however, only one of imbecility, and not always even that, and many show a great amount of shrewdness and cunning with defect of moral sense often accompanying it.

Long-continued epilepsy even in a young person of fair mental capacity may end in the patient becoming completely demented. It does not necessarily follow that every case of epilepsy terminates in dementia, nor is this most frequent in those with what are popularly termed the "severest" fits; the chief disposing factor seems to be the frequency of their occurrence, and general dementia is quite as likely to follow repeated attacks of petit mal; the truth being of course that the outward severity and duration of the convulsion cannot be considered as a correct indication of the severity of the disease.

Though it is theoretically possible that a patient may for a long period suffer from attacks of epilepsy, and yet no variety of insanity develop; still the more one sees of all these cases, the more one becomes inclined to believe that each convulsion does add its particle of injury to the already diseased brain, and that a certain amount of at least mental weakness almost invariably results.

Very few epileptics are quite like normal unaffected people. There is almost always a difference which goes on slowly increasing as years pass by, and very many show this in a marked degree ; they are incapable of higher education, of efficiently filling positions requiring a clear intellect, many of them are irritable, untrustworthy and not to be depended on, some being suspicious and irascible, while others on the contrary are simple, weak and easily led, and in all as life continues, the prevailing conditions become more marked and more discernible. In this particular it is difficult, of course, in face of this statement which is undoubtedly true, and the result of actual experience in this country, to account for the widely-spread belief that certain noted characters in history, Napoleon and Cæsar for example, have been epileptics, but it is not at all certain at any rate in the mind of the writer that the attacks described in such people were not more the result of periodic exhaustion and the depression common to many people of high intellectual development, especially among the races of Southern Europe, and on the other hand, there is no very strong ground for believing that any ever suffered from true chronic epilepsy.

In an asylum practically the convulsions have to be treated or at least considered apart from the insanity, which latter does not call for any special measures. It is very doubtful whether Bromides or indeed any other drugs do have lasting influence in arresting the fits. It has seemed to the writer that a strict course of dieting, certainly in Europeans and Eurasians, has had more beneficial effect than any other method, the food being restricted to vegetables, milk, butter and cereals ; all alcohol, meat condiments, and tobacco being forbidden ; but honesty obliges me to confess that many of the worst cases are seen among natives who habitually diet themselves in this manner.

Epilepsy is, however, a disease in which it is never safe to prophesy and to form any prognosis, as it sometimes quite suddenly ceases without any obvious cause or treatment. I have seen a youth of 24 who was notorious throughout the country round Nowshera for his affliction, which he had then had for many years at very frequent intervals, who came to us covered with burns and injuries received during his fits, and who from the moment he entered the walls to the day he left it over a year afterwards, never had a single fit. No history of head injury could be detected, and no possible cause to warrant it being termed other than idiopathic.



Everybody will remember cases in which treatment carried over many years has been, on the other hand, absolutely fruitless, and yet at the same time will recall other cases when, coincident at least with the treatment, it seemed for some years to gradually diminish, and finally almost disappear. The only explanation one can offer is, that in some of these latter cases some area of the body, that had hitherto formed an epileptogenous zone, no longer acted, and that though the area of unstable brain may have still existed, its peripheral source of irritation was thereby removed.

It is almost needless, of course, in ordinary treatment, to remind readers of the great danger to life in all epilepsy; the fits occur suddenly without warning, and the patient having no means of protecting himself may fall and drown in 6 inches of water, or may burn himself to death. Very few epileptics pass through life without some mark of injury, and many, from inattention on the part of their caretakers, are suffocated, drowned or otherwise killed.

Lastly, it may always be also remembered that death can occur in and "by" the fit itself: this generally happens in the tonic stage of convulsions, and I have always found *post mortem* in addition to general anæmia of the brain, the heart to be strongly contracted and absolutely empty, and am disposed to account for its occurrence by imagining the general tonic muscular contractions to extend to this latter organ and so cause the fatal result.

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## CHAPTER XXI.

### SYSTEMATISED CHRONIC DELUSIONAL INSANITY OR PARANOIA.

This disease which, though of great importance, is comparatively rare, only forming about 2 to 4 per cent. of those in European Asylums and infinitely less in Indian ones. A patient who appears otherwise sane, with perfect consciousness and memory, good judgment, no emotional disturbance, and with coherent speech, has yet a delusion of a coherent systematized character, and gradual growth which influences his whole conduct and thought,—an insanity often popularly described as monomania.

It is more common in men than women, is a disease of adult life and is peculiarly slow in its growth and onset. In a large per-

centage of the cases there will be found a definite "neurotic" heredity in the patient, and very frequently there will be a history given of some peculiar characteristic in childhood, that the boy was a "ne'er-do-weel" or more often seclusive, shy, solitary, or of a highly egotistical temperament.

The onset is always most gradual and may extend over years, just as the whole growth of the disease may be spread over many.

What usually happens is, that a morbidly introspective man, much given to his own thoughts, begins to be suspicious of every one about him, imagining that they avoid and shun him. A state of suspicion is the fundamental tone of the malady, though the presence of a delusion is the central feature. Slowly he begins to suspect that people are against him, that he is disliked or is watched, that people point at him, talk of him; being solitary himself, he thinks the reason is that people shun him. Finally, he weaves a long elaborate belief of some system of persecution set up against him, usually commencing in some occurrence that has actually taken place, and this point too may almost always be noticed, and is unlike the delusion met with in other varieties of insanities. So slowly does the belief form that it may take years during which his friends and those about him have noticed nothing. Very frequently such a man will abandon his occupation, change his place of residence in hopes of avoiding those whom he believes to be his enemies. Arrived at his new abode, after a little, he again thinks that others point at him, speak of, or at him, and again he changes his dwelling; doing so it may be several times in a year, and this frequent changing of his abode is very typical. So suspicious do these people become that often they will carefully hide their delusions, and it is only some peculiar act or habit which will reveal it; he will only take one kind of food and that prepared by himself, or he will take peculiar means to guard himself, etc. Unlike other insanes, they will not readily dilate on their feelings, and will, when questioned, furtively eye the interviewer and avoid the subject. Rarely in this stage they will commit suicide to free themselves from their misery, though more often they will make some sudden attack in retaliation for what they believe is being done; and this class of patients are of all insanes the most dangerous, especially when, instead of referring their "persecution" to some class, sect or body, they refer it to some one person.

If they can be induced to relate their beliefs, it will be found

that they have elaborated, and will tell with a calm conviction, most striking, a detailed delusion, founded usually, as before stated, on some actual occurrence for its starting point, and marked out with details often true in themselves though misinterpreted; indeed, their story is really a chain of explanation of actual occurrences, quite different in this respect from the described delusions of a chronic maniac. Because someone coughed or looked as they passed, that must have reference to them; the colour of a person's dress was assumed to annoy them, etc., etc.; nothing is too trifling to be so misinterpreted and no reasoning or proof will in any way shake their conviction. Though they have no "insight" into their condition, yet with all this they have perfect memory; they work, act, speak and reason on all other subjects properly, and in every other particular may appear to the world as absolutely normal beings.

As the years go by, they begin to suffer from hallucinations which still further strengthen their idea of persecution and support their delusion; the most frequent senses affected are those of sight and hearing, but all may be involved. Whereas formerly he only believed that any two people talking together were talking and plotting about him, he will now "hear" their allusions to him; whereas he formerly believed that poison was put in his food, he will now begin to taste it, smell it, or see it mixed. Of all the senses, undoubtedly hearing is the most commonly affected, and nearly all such people sooner or later begin to complain of the shameful way in which they are persecuted by what people say of them; still a large number also complain of sensory disturbances, that people pinch them, prick them, stick pins into them. On this point they become quite unreasonable, and men sleeping on the stone floor of a locked cell will, as I have seen, declare that nightly their enemies stab them through it. Now, for the first time, they may become emotional; with cries and imprecations the sufferer will demand protection from his tortures and persecutions, and nothing is more dreadful than the sight of such people when at their worst added to one's utter helplessness to aid them; curiously, they vary from day to day, and after a few days, while retaining their belief in their delusion, will not suffer from the hallucinations which the next night (they always seem worse at night) will recommence as bad as ever. If educated, such people often use some scientific discovery as an explanation to explain the power their supposed enemies have of injuring them; it is done "by

electricity," "magnetism," Röntgen rays, etc., and with each successive scientific discovery a new name is coined to account for what they feel and believe that they feel. A very frequent belief in such people is that their thoughts are read and others complain that their sexual organs are nightly tampered with, and women will declare that they are periodically violated by unseen agency; such patients also being extremely dangerous and likely to revenge themselves. At a still further period of the malady the patients begin to cast about in their minds as to why they should be so persistently tortured or selected for persecution, and then gradually the belief also springs up that they are some great personage wrongfully kept out of their rights, that they have been changed at birth, etc., etc., and that this accounts for it, and the delusion is strengthened often by hallucinations; the patient imagines he hears people own that he is some great person, a prince, a raja, etc., and it is obvious how this may still further lead them to be likely to take revenge on any one whom they fancy to be the prime agent in obstructing their rights. The original delusion of persecution may then become associated or partly replaced by one of grandeur, and it is at this stage that the patients may become arrogant, proud in bearing, take on peculiar habits, dress and speak in accordance with the rank they believe their due, etc., and that they may become troublesome by always demanding extreme deference and attention.

It is peculiar how such a patient will distort every occurrence of ordinary life into some subtle reference to himself and to his position and to the truth of his assertion, and how he will now recall an event long since past, deducing evidence from it and as to what was meant by it, declaring that though at "the time" he was foolish enough to have not observed it, now he understands it all, etc. Egotistical like all insanes, he believes that everything happening around him has reference to himself only and no reasoning will shake his conviction.

It cannot be sufficiently insisted on that these cases are extremely dangerous and often become quite unexpectedly so. A man deemed by all, if not some, to be at the most "eccentric," will quite suddenly make some violent attack on someone in the belief that this person is at the bottom of all his troubles. In a similar manner such people will become exasperated against their family, though it has happened that a patient will succeed in infecting another of neurotic heritage (and only those of neurotic

inheritance) with his belief, this rare occurrence forming an example of what is described as "Folie à deux" or communicated insanity. In any case, for all these reasons such people need seclusion in an asylum, though at the same time it is often extremely difficult, so suspicious are they, to obtain sufficient evidence of the substance of their delusion to make out a certificate for the purpose. The disease is quite incurable, treatment is unknown, and it is of extremely long duration. If it began in early life, it may be ultimately closed by the patient becoming demented. It is most common, however, after 30, and in quite a large number the intellect apparently in other subjects remains unclouded until late life.

To recapitulate them, the stages are :—

(1) Onset of introspection and suspicion and weaving of a delusionary explanation of persecution.

(2) A systematized elaborated delusion with hallucinations supervening.

(3) A period of exaltation when the patient explains (2) by believing himself an exalted personality.

(4) Very rarely a termination in dementia.

The leading feature being that hallucinations follow the delusion and do not precede it.

The chronicity, incurability, its constant element of suspicion and the apparent freedom of the remainder of the intellect and the dangerous nature of the patients.

We have here (1907) an excellent example of this disease in a Mahomedan Jemadar, late of the Hong Kong Military Police, who has gradually evolved an elaborate delusion of being persecuted by a Sikh deputation on account of a book that he actually did write some years ago, defending the Mahomedan religion against that of the Sikhs. He declares that the deputation intended to kill him and followed him everywhere under disguise even of his fellow lunatics. He is now also developing hallucinations of hearing, and declares that he is constantly hearing three men whispering arrangements for his killing, that they have powers to do this through the walls and roof of any cell, however well built, into which he may be placed, that he tastes poison they have placed in his food. To exemplify the dangerous character of such cases it may be added that before arrest here the man went to the Deputy Commissioner, demanded protection at night by a police guard from his enemies, and that having been

placed in the thana unsearched, he suddenly attacked one of the guard with his revolver. Yet with all this he is a clean, quiet, well-behaved, orderly, sensible man who, when not alluding to his delusion, looks, speaks and acts and reasons like one sane, has perfect memory and can advise others. Speak but of his delusion, and he is at once utterly unreasonable, and no amount of ocular demonstration will convince him of the foolishness of his arguments. Some such patients are always believing that certain acts of people,—their dresses, the colour of these, of the number in which they see articles arranged in pairs or three, etc., are symbolical of some hidden meaning, having reference to their delusion, and this peculiarity may be such a prominent feature as to be described by some authorities as a special form of disease, symbolising insanity.

As regards the diagnosis of this from other mental diseases in which delusions are very prominent, it must (i) be remembered that dementia paranoides in which delusions often of a temporarily very systematized character are a very distinct feature may present great difficulties, still the early age of the patient, the coincident symptoms of emotional disturbance in conjunction with the rapid or comparatively rapid onset of the disease, the fact that the delusions are not very stable and rapidly fade away serves to distinguish it from true paranoia with its one persistent, elaborated, highly systematized delusion which is the sole feature and which only becomes more permanent, more highly elaborated and more insisted on as years continue.

(ii) Many chronic maniacs as also some melancholics, after they have lost their acute symptoms, are left with a prominent delusion even somewhat elaborated, but then in the history of its mode of onset there is usually marked emotional disturbance, the delusion is not so clearly systematized, nor is the patient otherwise reasonable and clear and well-behaved, and hallucinations in this case precede the delusion and do not follow it only as in true paranoia. Delusions of persecution are also rare in chronic mania.

(iii) Alcoholic paranoia perhaps resembles the true variety most clearly. In these there may be a coherent delusion of persecution, but this is usually accompanied by hallucinations not followed by them; its onset is usually comparatively rapid, the delusion is not so elaborately marked out and there are the physical symptoms, the fine tremor, the facies and history to help one.

(iv) In a few cases of G. P. I. is a delusion of persecution present, but the physical symptoms are here distinctive.

The delusions of persecution often evolved in paranoia must be distinguished from those sometimes seen in delusional melancholia, though this in a few well-developed cases is often very difficult; roughly, however, the melancholic attributes his persecution and torments to his own wickedness or vice, or to his low nature, whereas the paranoiac believes that he suffers from the envy of others who wish to destroy such a great, able or exalted personage.

Obviously a delusion and the hallucinations accompanying it may have their starting point in some disease, the sufferings of which the patients interpret insanely. We had here a man suffering from spinal sclerosis who accounted for his symptoms as the result of injuries from his enemies, and patients with cancer or other forms of diseased digestive organs will also develop hallucinatory beliefs in this manner.

It may be here added that hallucinations of unseen agencies are always most marked at night, the patient's thoughts and attention being then concentrated on them, and freed from any conflicting impressions such as usually arise during the day.

Paranoia is practically the only variety of insanity except some cases of melancholia, for the purpose of suicide, which is ever concealed, and some of these patients who fear restraint or desire revenge, or in whom the delusion is of very slow growth, will for a long time carefully conceal their delusions, and the greatest difficulty may be experienced in detecting them even when certain peculiarities of the patient leave little doubt that such exist. This is increased by the fact that all paranoiacs with delusions of persecution are in general extremely suspicious, and regard every questioner as having full knowledge of what is to themselves obvious, and for that reason refuse to give any information.

In India where of all countries of the world it is most rare to get any reliable family history or clear account of the origin of a disease, it is not always easy to distinguish from these cases those of a maniac or melancholic who has lost all his acute symptoms, dropped his emotional condition, and now remains simply with some fairly systematized delusion that has gradually evolved itself out of the remains of his original condition, of which there may be absolutely no history, while similar cases may be pointed out with the clearest history of evolution in the asylum by the

dozen, and, like the former, were we not given the details of their previous state, would be very difficult to distinguish from the clinical "idiopathic" variety. They are, however, not so characterized by suspicion; the delusion is rarely perfectly systematized; some other insane trait co-exists, and they do occasionally recover, a point which renders their accurate diagnosis, when called on for an opinion, a matter of great importance; such may be conveniently termed Unsystematised Chronic Delusional Insanity.

For when all is said, it is extremely difficult to class some of the varieties of insanity in which, when the patient is seen (often in this country, with no possibility of obtaining any reliable previous history), a delusion forms almost the only symptom.

Generally, it will be found that these are instances of cases of previous insanity (mania) that have recovered in almost every particular, and only a delusion remains, colouring the whole life of the patient. A complete example of this character, though possible, is very rare; generally there is some emotional intellectual defect, some insane habit or peculiarity, some loss of general control which gives the key; the condition of reticent suspicion is not seen, the patient is very ready to talk of his delusion, and this is not completely systematized, is not an erroneous interpretation of a real event, it is not reasoned out, nor is the conduct bearing in harmony with it. Endless examples, varying in these accompaniments, are to be seen in an asylum; here we have an old grey-haired man who, with calm, quiet conviction, informs you that he has made an engine with which he can level mountains and fill up valleys, and on which he can go in one moment from here to Europe; who will detail all the particulars of it; where it now is, how it has been temporarily taken up to Heaven, and where it has been sent for some repairs, etc.; who can give you always some specious reason for not showing it, who is never at a loss for a reply on the subject, and who, otherwise, is a quiet, collected, clean, orderly man, with good memory, fair judgment on other points, and with no defect of will power. Such a one with his almost "systematized" delusion contrasts very forcibly with the fleeting, disordered, changeable statement of a maniac, who in the intervals of jumping about, singing and dancing declares that he is as powerful as a giant, can pull a buffalo out of the canal by his tail, can print any paper, can cure plague, etc., is most beautiful, handsome, tall and wise; all of which was told me by a short fat boy of 15 who rapidly recovered after an attack of mania, but this one could



give no details, he would wander off the subject in a few seconds and was incapable of exercising the least self-control. Still more unlike this is the continual wailing statement of another, that he is dead, his body has mortified, that his inside is stuffed up, that he can pass nothing from his bowels, but who can assign no other reason than a vague feeling of discomfort and general misery, and whose delusions will vary from day to day. The more definite delusions approaching systematized delusional insanity are not necessarily accompanied with exaltation as is supposed, for their emotional contents vary with that of their delusion. A man who believes himself to have offended a faqir by scoffing at him, to have been cursed by him; and that he is as a result slowly wasting away; or the man who believes that he is rightfully the possessor of crores kept from him by powerful oppressors, who have finally consummated their villany by putting him in an asylum, is necessarily usually depressed and miserable; while another who believes that, like the old man referred to, he is an all-powerful inventor, is sufficiently pleased with a sense of his power and ability, even though this is not recognised by the world at large, to be vain, self-satisfied and exalted.

It is this disease par excellence in which hallucinations are the primary symptoms. Almost all cases of delusional insanity have these, and there is little doubt that in most of these cases the delusions arise in this way instead of their being secondary as in true paranoia. Hallucinations are found, and eventually a fixed belief to explain them is reasoned out. The most frequent are undoubtedly auditory; the patient complains of hearing voices, his thoughts are repeated aloud, nightly visitors come and talk into his ears, etc., etc. Others see visual hallucinations, visions, forms nearly always of a definite character. Others suffer from peculiar sensations that they attribute to some influence and persecution, and quite a large number complain of a bad taste or smell—disgusting materials, very frequently fæces as they believe being mixed with their food, gases are mingled with their milk and drinking-water, everything they eat or drink is poisoned. Such cases are in a large number of toxic origin—many in this country being of men addicted formerly to *cannabis indica*.

(1) There is now in this asylum a native who believes that in a cellar (a *tye-khana*) beneath the compound is confined a European lady who nightly ill-treats with the assistance of some other people, either the children she gives birth to or some of his

own relations or friends. He professes to be able to hear them distinctly at any hour of the day or night, and if questioned will invite us also to listen to the cries of his sister who is thus made to suffer, and declares that at night he can also see them.

Regularly at each morning visit he comes up and gives us a detailed account of the atrocities that have been committed before his eyes the night before ; and though he, whenever he happens to be standing, always indicates that as the place of the cellar, and though he has repeatedly detailed injuries that must obviously have killed anyone—and the next morning relates the same sufferer as being yet alive—yet he is otherwise sensible, a good worker, orderly and has a good memory.

(2) Another man believes that his wife is kept in prostitution by his enemies, the inhabitants of his village, instigated by some high officials, and that he is hunted throughout India by their unseen agency, that all his food and drink "are poisoned," that nothing, even milk that he sees drawn before his eyes, can escape being so contaminated before he can raise it to his lips, all this being affected by "Röntgen Rays" and the latest scientific discoveries, and though a well-educated, English-speaking, most sensible, quite collected, reasonable man in every other respect, cannot see the obvious contradictions and fallacies of his belief.

Patients with this disease have always a tendency to take for the basis of their delusion any person at that time prominently before the public, and are particularly prone to utilise any striking scientific discovery in explaining their hallucinations and delusions such as X rays, Finsen light-telepathy, etc. The majority evolve ideas of persecution, though, as before said, a smaller number, and it is these that are free from hallucinations, are exalted in character and produce an unfounded idea of well-being, power and capacity. Indeed, it was to these cases of fixed delusions of exaltation that the name of monomania was formerly given. As a rule, however, except when the delusions of persecution arouse bitterness, and a desire for revenge on the supposed author of their ideal suffering, the emotional condition is neutral, and such must be taken as the typical condition of the disease. Ideas of persecutions, however, are very common, and such cases, when they once attribute their sufferings to some person or class, are most dangerous, they will carry concealed weapons and will in obedience to an hallucination of hearing, etc., attack any unfortunate passers-by they suspect of being the authors of them.

Great stress is laid by all writers on the fact that, except on the subject of their delusions, sufferers from the former form of insanity (paranoia) have good judgment and reasoning powers and show no intellectual impairment. It must, however, be pointed out that in strictness this, though apparently true, is not entirely so. Such patients rarely show any brilliant intellectual attainments, and all our knowledge of mind goes to prove that the interaction of all its constituent parts are so great, that it is impossible for one considerable factor of it to show an absolutely diseased product, such as a delusion without a certain impairment of the whole. and such can easily be seen to be so.

The uncrowned King who will detail to you all the power and wonders of his dominions, his great possessions, etc., will at the close of his narrative conclude with a demand for a pice, and will fail to see that were he so powerful once outside the asylum, it is absurd to suppose that one or other of the underpaid attendants should not for the sake of future reward assist him in escaping. The "King of the Jogis" that we had here with "nine large rubies" in his private property in the asylum chest, "each worth as many rupees as there are in the treasury of eight rajas," never thought of disposing of one to purchase the extra tobacco he was always asking for, and so on *ad infinitum*.

A very little careful study of these cases will convince one that there is a decided intellectual lowering of all. Their intellectual level is low, and their arguments more shrewd and "tricky" than carefully thought out. Memory, however, certainly remains perfect up to advanced age, and ordinary thinking, speaking and acting in every-day matters not affecting the delusion is sufficiently good to mislead a casual observer. It might be urged that certain cases of religious fanaticism, fixed habits, etc., show no essential difference from delusional insanity. For instance, that among Europeans the founder of a new sect, a man with a special mission to save souls; or among natives that a new reformer, I need not detail instances, Hindu or Mahomedan, are in reality instances of such. Well, there are, however, certain essential differences; such people, especially among those of lower station in England who start religious sects, are generally of very low education; their opinions are often the result of ignorance and defective capacity for judgment and observation, and not proper deductions from religious works and the Scriptures. They are frequently vain and of a "seething imagination." On the other hand, an insane believes himself to be the

Mahdi, the Christ, a prophet ; his history, if it can be obtained, shows that he was formerly perhaps an industrious, sensible man, and that his present opinions are the relic of a preceding attack of mania from which he has apparently recovered, but with a complete alteration of his temperament, beliefs and manner ; the former quiet, orderly man being now irritable, suspicious and quarrelsome. Also that though in most cases the same religious fanatic or mystic, turns his opinions to profit, being always the head and ruler of any sect he may form ; the insane is so convinced of the truth of his delusion, of his fixed belief that he retains it when his advertisement has cost him his liberty ; and often works quietly, perfectly satisfied with a sense of he himself being right, though the rest of the world is so foolish as to repudiate him, his works and teachings, and rarely does any such case attempt to make capital out of his beliefs.

In this country the number of sufferers from delusional insanity seems less than in Europe, while naturally the contents of the delusions seem to follow lines in agreement with the mode of life here and its surroundings ; the patient also taking as agents in his persecution to a large extent either possibilities of which he has knowledge, or the various unseen and impossible agencies which are locally believed in. The varieties, of course, are endless.

In the asylum at present we have a man who believes that his enemy, a dhobi, lives on a tree close by and is continually abusing him ; no ocular demonstration will, of course, convince him that no tree visible contains a man in it.

Another, blind for many years, declares that his enemies continually throw fire on him, and so habitually goes about with his head covered in a blanket. Another believes that he is nightly put to death by the attendants here, and only resuscitated in the early morning by the power of a friendly faqir.

Another old man, arrested for a habit he had of sitting beside the road, and assaulting all who passed at a certain time, explained this little peculiarity by asserting that his shadow was God Almighty, and that people passing in front trod on it, and that he could not allow the Deity to be desecrated by the feet of anyone. Yet another declares that his inside is a river, and that everything he eats or drinks must in consequence be given to him in enormous quantities to satisfy him. His appetite and capacity for eating are not, as a matter of fact, greater than that of any other, but to this fact he pays no attention. These examples are all undoubtedly of

the secondary type, i.e., are residues from a previous acute attack of insanity.

The only possibility of cure in these cases of C. S. D. which arise primarily and then only in their early stages is an absolute change of scene and removal to a sphere where all the company, habits and mode of life are novel; and all patients of neurotic family history who exhibit any of the peculiarities so often noticed before the outbursts of this disease, should always be compelled to lead an active outdoor life and to mix freely with the world, in fact to do everything to avoid excessive self-absorption and introspection. The disease, when once fully developed, is almost always incurable, but those cases which arise as a relic of preceding mania and melancholia can sometimes be cured by the life and routine of an asylum; should this not happen, they almost always slowly become weak-minded and end completely demented.

Many cases of morbid suspicion, or those having ideas of chronic poisoning, being practised on them, etc., frequently die of pulmonary tuberculosis.

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## CHAPTER XXII

### OBSESSIONAL AND IMPULSIVE INSANITY.

#### *Insanity of Imperative Ideas.*

Nearly everyone must have had the experience of having had at some time or another (more especially when in weak health) as we say in English, "an idea in their heads that they cannot get rid of." A rhyme or phrase that refuses to go, or a persistent idea that they have not done something that they should, that they have not shut a door behind them, that having written two letters have put each in the wrong envelopes, until the persisting of the same obliges them to go back; to see if the door really is shut, to reopen the envelopes to see if the letters really are properly addressed, etc., etc. Others among us must have often experienced a strong desire or impulse to do some foolish thing, to break some article, to jump off a platform on to the train rails, or in walking along a cliff or standing on a high gallery to throw oneself over. Such ideas, desires, impulses are met with in numberless normal people, and are overcome, but in others—abnormal—the thoughts become so imperative, the feeling of doubt is so insistent, the impulse to do something is so overpowering, that the unfor-

fortunate patient, instead of controlling them, is controlled by them, and a pathological condition, the insanity under discussion, arises. An obsession is a persistent idea that its possessor cannot escape from, while a morbid impulse is a desire, an idea so powerful that its possessor is compelled to act on it. Such people are usually of neurotic family history, in the classical examples their consciousness is quite clear, they understand everything perfectly, reason properly, have perfect memory, and no hallucinations or delusions can be discovered. Yet their will is incapable of freeing them from the persistent idea or impulse.

These people will, one of them, complain that he or she is for hours at a time haunted by some obscene thought; another, that he cannot look at anyone without picturing something of the kind; another is tormented by the idea that he may have a piece of glass or a pin in his clothing, and is continually stripping himself to make sure that he is mistaken; another fears that he may have defiled himself by touching anything no matter what, and be continually bathing in consequence. Another will not approach a fire lest he might, as he is continually suggesting to himself in his mind, drop something in it. It is obvious that these cases verge into those various "fears" that are sometimes described as characteristic of this disease, though they more properly are believed to result in or after neurasthenia. One such dare not cross a road, declares that if he attempts to do so he becomes giddy and will fall; another cannot mount a staircase; nor another enter a carriage or a railway train; he declares that he instantly feels suffocated and insists on stopping it and alighting. Whatever opinion may be held as to these latter conditions, it must be remembered that in advanced cases quite apart from the fact that his mind is always dwelling on the point, these feelings, thoughts and dreads so overpower the patient that he can do nothing, he abandons his occupations, often going from one place to another, seeking relief; in severe cases he will spend his entire day a slave to his affection, undressing to search for possible source of injury, washing his hands to avoid contagion, and the distress and terror they feel at any effort to combat their idea is very evident. A more important variety, socially at any rate, is that of impulsive ideas, a desire to do some act which the patient cannot resist acceding to. Several cases are on record where men have come and begged to be shut up, declaring that they had from time to time an overpowering desire to kill someone, to do some cruel.

vicious act. Murders have been committed, the man afterwards declaring that the idea had possessed him for days, for weeks, that he had fought against it, but that at last it had overpowered him, and that then he had committed the act, though the act itself was unattended with passion or excitement. All these patients uniformly describe the intense feeling of restlessness and anxiety that affect them while the "desire" is on, the rapidity with which, when they gave way, the act was committed, and the equally intense feeling of relief and ease the moment the idea had been carried into action; whether this was a criminal deed or merely some foolish act as such sometimes are, to open all locks they see shut, to open and read any folded paper, or trivialities such as overturning all large stones, or touching every tree on a road, etc., etc.

It is believed that such a form of insanity exists, characterised simply by the inability of the will to control some one idea or impulse, unattended with absolutely any other sign of mental disease. Such people being always of neuropathic heredity.

It cannot, however, be too strongly insisted on that it must be always remembered, first, that (1) if these cases are well and carefully examined, that in many some other evidence of insanity will be found, or there will be a history that the patient has been noticed as "changed" for some time previously, and, therefore, that the patient is an ordinary lunatic. (2) That impulsive acts to burn, destroy, to rend, tear, kill or commit suicide, are of course extremely common among almost all insanes.

(3) Congenitally weak-minded people, especially young females about the age of puberty, often exhibit a strong impulse to set fire to things; patients suffering from mania show an impulse to tear, destroy, break anything, and others to be perpetually stealing usually useless articles. General paralytics in the early stage may show an impulse to steal, others to assault or to murder. Melancholics have often a strong impulse to commit suicide. Mania after delivery is frequently attended with a strong impulse on the part of the mother to kill her child. Some epileptics after a fit often show an impulse to homicidal violence, etc., etc. As examples. There is a man here who seems possessed with an insatiable desire to stab people in the face; he has several times effected his purpose, once with a nail, at another time with a piece of sharpened wood, and again with a sharpened bone, but then this man has not spoken for 15 years, he writes what he requires, and explains in that way that his "pir" visits him and has ordered

him to do so. Another man goes up to in offending other patients, seizes them by the beard, etc., but then he is an epileptic and his acts are preceded by a fit. Another spends his entire life in seeking for some heavy article that he may carry it about and then stealthily drops it on the head of some unsuspecting person ; he never attempts to commit murder in any other way, but then he is constantly naked, and when given fresh clothes, calmly puts them off, folds them up neatly and finally defecates on top of them, and has a delusion that all his acts are so ordered by his guardian angel. Examples of these kinds of impulsive acts, even of very minutely specialised ones, are innumerable. Many of these others who appear at first to present examples of pure impulsive insanity with no(?) intellectual defect, will be found on closer examination to be epileptics, in whom the convulsion is replaced by the act ; such are often described as suddenly starting up to commit a furious act, without noise, but with fixed suffused eyes, flushed face, clenched teeth and rigid muscles, and what is still more distinctive, a momentary marked pallor can be seen to precede it all. The whole being obviously an example of masked epilepsy.

(4) In some other insanes a sudden impulsive act will be found to be the outcome of a concealed delusion, more especially if this is attended with hallucinations, the patient suddenly starting up to perform the act in revenge for what he believes he has heard. True impulsive insanity is not, however, accompanied or caused by a delusion, nor does it show hallucinations.

(5) In yet others an overwhelming impulse most often plus a causal delusion, but sometimes with absolutely nothing else, is seen to, at variable intervals, affect a man who has apparently recovered in every other particular from a previous attack of insanity. One case has come under my notice of a man who many years ago suffered from an attack of mania, and who now to a superficial observer would seem to have absolutely recovered, yet he from time to time seems to have recurring impulses to wound others with a cutting instrument, and has more than once effected his purpose.

When all these various exceptions are accounted for, the number of persons who show a classical, purely uncomplicated, uncontrollable impulse, to commit some one act more or less specialised and showing no other evidence of insanity, will remain very small indeed. But such a disease undoubtedly exists, its importance is of course great from a medico-legal point of view in regard to



responsibility for crime. It would be difficult for any medical man to conscientiously urge it as a defence, unless the clear history of nervous family heredity, the suddenness of the act, its having been done without a motive, alone and unassisted, or its having been of an unreasonable and unnatural character, and attended with the distress and restlessness of the unsatisfied craving, followed by the intense feeling of relief that is so characteristic, had convinced him of its genuine nature. Still stronger proof would, of course, have been the evidence of the man having complained of the impulse before or his having sought protection on that account against himself.

To those who disbelieve in the existence of such a disease, it can be very cogently pointed out that no one doubts the existence of obsessions, dreads and fears or of these being often quite uncontrollable; from these to a marked impulse impelling to some fearful act, it is only a question of degree, and it is difficult to see why one should be admitted as possible and not the other. This disease is of great rarity in India, though the "impulsive acts" alluded to as common in various kinds of insanity are of great frequency.

No treatment is known, and the sooner such a sufferer, if his impulse is of any dangerous nature, is secluded in an asylum, the better.

It is worth remembering that Dipsomania, the periodical craving for drink, is really a well-marked form of impulsive insanity and perhaps the most frequent one.

A well-marked variety which I have never met with in India is that described as the insanity of doubt with delirium of touching, "*Folie du doute avec delire du toucher*," in which there is a constant fear of defilement with hesitation to touch anything; such patients are analogous to those others of similar characteristics, who can never make up their minds, cannot decide whether to do a thing or not, take hours to decide whether they will move, whether it is right to touch this or that, wear this or that, and who pester everyone with hundreds of questions and interrogatories without ever coming nearer to a decision.

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## CHAPTER XXIII

### EPOCHAL INSANITIES.

Some authorities divide insanities according to the ages at which they occur and in particular describe adolescent insanity;

climacteric, involutional and senile insanity. With the exception, perhaps, of the senile variety, with its characteristic loss of memory for recent events, these do not in truth present anything typically distinctive, though certain varieties are more common at certain ages and so form sufficient excuse for the subject being especially described; and it is obvious that the bodily changes incidental to these various epochs can be sufficient in very predisposed people exposed to any additional "stress" at these periods to explain their frequency. In childhood idiocy and mental weakness are almost the only varieties.

(1) *At adolescence*.—At this period, the stress of work in preparing for and commencing the activity of life, the frequent occurrence of phthisis, the onset of sexuality and frequency of masturbation, etc., conjoined to the bodily changes, all explain the relative greater frequency of insanity at this time of life.

The varieties usually seen are: (a) Mania with conceit, overweening confidence and restlessness as predominant symptoms.

(b) Dementia Præcox which is the disease par excellence met with at this period, whether we regard it, as is the general opinion now, as a separate disease, or with older writers only look on it as an "emotional melancholia" and hypochondriasis "with liability to recur" and tendency to end in mental weakness (Savage).

(c) Almost all the cases of acute dementia (rare enough) seen here have been in people of this age.

(2) *Insanity of mature age*.—At this period almost every variety may be met with (though mania and melancholia are most common), and there is absolutely nothing distinctive except in the relatively negative point that Dementia Præcox is rare.

(3) *Insanity at the climacteric* is relatively common in those predisposed to such affections by neurotic inheritance, which is said to be found in over 50 per cent., and especially is this so when the inheritance is derived from the mother. It is most frequent among Europeans, in married women or in those single who have hard unsuccessful work of a character that gives them cause for anxiety as to their welfare in later life, combined with the profound bodily and mental changes occurring at this period. It is a variety of insanity uncommon among natives of India, probably from the difference of social habits.

The type met with is usually one of melancholia, though several well-marked cases of prolonged subacute mania, with recurrent attacks of rage and violence, have been seen here. As in most cases

of insanity, the natural bodily changes and those of the environment are misinterpreted by the insane patient. A woman suffering from insomnia and depression, with its accompanying inability to fulfil the duties of her position, and with failing sexual desire, begins as a result of this to be suspicious and jealous of her husband, changed perhaps in her affections for him herself; she interprets this as a result of his conduct, and of his being unfaithful, and losing interest in her, or she accuses herself of various crimes and infidelities to account for it, and may make a detailed confession of some imaginary crime. She has vague fears and oppressions, feels herself changed, suffers from hallucinations of hearing and vision and weaves a connected delusionary story to account for it all.

Delusions of persecution of any kind may in this way be evolved, all the occurrences and her own feelings being brought in support of her statement, and suicide is not uncommon. Certain bodily changes in addition to the cessation or irregularity of menstruation may be noticed, the growth of hair on the face, vasomotor, giddiness, flushings and headaches. Dyspepsia is common, which may account for the habit of drunkenness, sometimes commenced at this time, or that of constantly taking drugs.

The cases of melancholia, if treated by prompt removal from home, where they only suffer much themselves and cause great unhappiness to their family, are likely to recover after a prolonged illness, but where mania sets in about the age of 40, this usually continues for many years and most frequently ends in dementia.

(4) *Period of involution*.—This really corresponds with the climacteric and may be taken to include the period of from 40 in both sexes to that up to the commencement of old age, or practically between 40 and 60, and the type of insanity met with is almost invariably melancholia which in women is usually as described above, and in men has for its chief characteristic general despondency, inability to perform their usual duties, and hypochondriacal ideas of their being worthless, worn out, or afflicted with some incurable malady. It is always a prolonged affection and often ends in mental weakness and in persons over 50 is rarely completely recovered from.

Among European unmarried females, a few years after the climacteric, a form of insanity is sometimes met with deserving of passing notice. Delusions in these may arise of being in love with some one man, perhaps a person she may have never spoken to; the woman may even declare that she has been proposed to, and

no assertions of the friends or of the victim himself can shake her delusion. Such a patient by persistent following of the supposed beloved object and by her continual letters and assertions gives great trouble and annoyance.

A "presenile" form of insanity has been described by Kræpelin as rarely occurring (chiefly in women) between the ages of 55 and 65; in men a little earlier. In this with some impaired power of judgment there is the existence of numerous silly hypochondriacal and persecuting delusions in a patient who has been noticed to be gradually becoming moody, suspicious, irritable and depressed. The delusions are particularly senseless and not systematized or worked out; like those of paranoia they are not at first accompanied by hallucinations; they declare that their effects have been stolen, that husband or wife are unfaithful, that they are being persecuted. The delusions, too, in addition to being often of an obviously impossible character that they are cut open, headless, etc., are particularly changeable; they will be full of them at one moment and at another are ready to agree that they are mistaken and can usually be easily pacified. Occasionally there are intervals in which they become emotionally excited, abusive and boisterous. The disease generally, though it may lessen, continues for many years. It is practically unknown in this province.

(5) *Of old age.*—Insanity at this period is not a question of the actual age of the patient, but of his physical condition, and indeed bears a direct relation in most cases to the condition of his arterial system, almost all such patients showing this in a degenerated abnormal state, thus accounting for the malnutrition and progressive degeneration of the brain ultimately causing the condition; while it is obvious that the organic brain diseases, hæmorrhage, softening, etc., are most common at this period of life. The insanity of senility has been alluded to separately under organic dementia, and it is sufficient here to point out that in old age there may be a condition of (1) melancholia rarely recovered from, and frequently fatal, usually attended with ideas, *i.e.*, (2) delusions of bowel obstruction, etc., or a condition of (3) mania not in any way distinguishable from other types, except that it is important to remember that with the loss of control and with the excitement and general feeling of power and virility old men who have previously been most well conducted and moral may commit some sexual

impropriety, talk obscenely to some one, expose themselves or make criminal assaults on young females, so that all such cases ought to be very carefully supervised. (4) By far the most frequent change, however, is one of gradual dementia which has been separately described and which is usually persistent and incurable.

## CHAPTER XXIV

### PUERPERAL INSANITY.

Insanity is frequently stated to have begun in connection with pregnancy, either during the period following delivery or during lactation, and most authors describe "puerperal insanity" as though this were a separate disease, whereas either mania, melancholia, or dementia may be met with in this connection, and if it be remembered that (1) almost all women become pregnant at some time, and many spend many years of their mature life (the great period of insanity) in child-bearing, it is not surprising that in a predisposed person the two occurrences should have a time relation together; (2) that many of the cases seen in this connection are simply attacks of insanity due to exhaustion from prolonged labour, septic inflammation, and that of prolonged lactation, and, therefore, are in no way different from exhaustion psychoses arising from any other causes of this nature; (3) that as almost invariably these insanities happen in people with a "neurotic inheritance," it is more reasonable to regard the attack of mental disease as following the great physical disturbance, the worry, anxiety and shock that the condition of child-bearing so often gives rise to. Certain it is that there is nothing absolutely distinctive in puerperal insanity or absolutely characteristic, although its occurrence is so frequent as to warrant it being considered separately in clinical teaching, and for convenience it is so here.

As before said, most of the patients have a definite neurotic family history; not infrequently there is a history of the mother having also been insane at this period. Insanity is also more frequent, if the exciting cause that pregnancy undoubtedly forms is intensified by anything likely to increase the worry and anxiety natural to that period; thus, if the child is illegitimate, if the husband has died or deserted the mother, or if for any reason the labour is

regarded with great dread and terror. In predisposed women, a first pregnancy after the age of 30 is regarded as particularly likely to be attended with mental disease, as is a long interval without child-bearing. In all male pregnancies the risk is greater. Just as most insanities show a tendency to recurrence, although a second pregnancy is not by any means necessarily followed by this, still it is very frequently, and the period of commencement is also often quickened, that is to say, that a woman insane at delivery with the first child may very likely become insane about the seventh month with the second, still earlier with the third, and so on. Once insanity has followed pregnancy, the danger of its recurrence with a similar condition is a very real one.

General paralysis of the insane has been seen occurring in pregnant women. Katatonia has its beginning occasionally during gestation, but with these exceptions, it may be roughly stated that insanity during pregnancy is usually melancholia, at delivery or shortly after is most often mania, or if not that, then the variety of melancholia known as agitated, and that during lactation melancholia is again most common, indeed, almost invariable. A first attack of insanity at any of these periods is very frequently recovered from, though several cases have been admitted to this asylum, who have continued for many years in a condition of chronic mania, and a condition of permanent mind weakness is fairly often met with.

The insanity of pregnancy, usually melancholia, is often at first, a mere accentuation of the symptom met with in normal persons at that time; the depression brings anxiety, the longing desire for unusual food, etc., etc., just as later the sickness may be misinterpreted into a delusion that some one—usually the unfortunate husband—is poisoning her. Sleeplessness is very marked and suicidal attempts very frequent. Except for the fact that, as in all varieties of puerperal insanity, an intense dislike may be conceived to the husband and unfounded accusations of misconduct or bad treatment made against him and that the patient very frequently accuses herself of various imaginary crimes, often unfaithfulness, this type of melancholia shows nothing distinctive. Like all such, she is unable to perform any household duties; she is usually more depressed in the morning. Suicide is particularly likely in these cases. If the patient has become insane before the fourth month, there is a great probability of their recovering

after that period—*i.e.*, at quickening. If it commences after the fifth month, then it usually continues for some period after delivery. In no case is the induction of premature labour of the smallest service, so far as the mental symptoms are concerned, except in that it may obviate the possibility of an idiotic child or one predisposed to insanity being born.

In the second variety, a woman becoming insane at or after delivery, the condition is usually mania. There may be a short attack of this actually at the time of delivery from the excitement, pain and anxiety in a neurotic woman, but such usually ceases with the relief afforded by delivery. Mania may commence very shortly after delivery, it then lasts for a few weeks and is usually recovered from; it may be regarded as an exhaustion psychosis. The third day (sometimes attributed to the onset of the flow of milk) is a very frequent time for such an attack to supervene; it may then very occasionally be cut short by a strong purgation or a sleeping draught (in every variety of puerperal insanity it may be here stated that prolonged insomnia is a great predisposing cause and is also a marked symptom); agitated melancholia may sometimes be met with in place of mania. The mania here met with is usually attended with great restlessness, physical prostration, erotic manifestations, with dislike to husband and child and aversion to relations and nurse, mistakes in identity, refusal of food, sleeplessness and hallucinations of smell, taste or of sight and hearing. It is obviously a result of exhaustion and must be treated on that assumption; while it is also most important to guard against the formation of abscesses in the breast and retention of urine, which the patient, restless, noisy and excited, is very apt to fail to call attention to. Also it must be remembered that there is a real danger that, if not watched, the mother may kill the child. Just as in cases of insanity during pregnancy, labour pains may be disregarded and the mother be delivered alone and the child die or suffer injuries or be murdered by her. Curiously, there is often in these cases no recollection even of the child having been born afterwards. If agitated melancholia occurs, the mother is extremely likely to accuse herself of imaginary infidelity or to commit suicide. Occasionally, during the course of either disease sudden marked remissions simulating perfect return to health may be seen.

One case has come under my notice of mania commencing in the late months of pregnancy in which the pains of labour were coincident with a complete return of reason for that period, but the woman became again insane immediately the child was born, and continued so for some three months afterwards, ultimately making a complete recovery.

Septicæmia following delivery in predisposed subjects is very likely to be accompanied by mental disturbance of the nature of an infective delirium, at first great motor restlessness, confusion of thought and speech, mistakes in identity and refusal of food, with visual and auditory hallucinations, and later, low, muttering delirium, jactitation, sordes on lips and teeth, and brown furred tongue. Curiously, as has been pointed out, by observers in these cases, the temperature is persistently subnormal throughout; the treatment is that of the septicæmia plus careful nursing. During lactation insanity may also occur, and is then usually of the type of a mild melancholia; the patient has ideas of being unworthy, wicked, unfit to live, and frequently attempts suicide or to kill the child; such cases are usually a result of exhaustion from the prolonged drain of feeding the infant, and if this be stopped, and the mother carefully and liberally fed and made to rest, recovery usually quickly follows. In a few, however, in whom the insanity of this type commences after weaning, the disease is of a very prolonged, persistent kind. It must, however, be owned that the variety of chronic insanity and that resulting in dementia which bears a relation to child-bearing usually met with in this country is in the experience of the writer, usually mania following shortly after delivery.

The various varieties may be summarised therefore as follows:

**A. During Pregnancy—**

- |                           |                |  |
|---------------------------|----------------|--|
| (1) Before the 4th month. | } Melancholia. | (1) Usually ceases during later months of pregnancy. |
| (2) After that period.    |                | (2) Usually lasts some months after birth of child.  |

**B. With Delivery—**

- |                                  |          |   |
|----------------------------------|----------|---|
| (1) At the time of labour.       | } Mania. | (1 & 2) Usually transitory.   |
| (2) Immediately after delivery.  |          | (3) Usually recovered from, but a small proportion becoming chronic or terminating in dementia. |
| (3) About the 3rd day and later. |          |   |

(4) With septicæmia. An infective delirium, frequently fatal.

**C. With lactation—**

- |                                   |                |                                     |
|-----------------------------------|----------------|-------------------------------------|
| (1) During lactation.             | } Melancholia. | (1) Usually readily curable.        |
| (2) Following soon after weaning. |                | (2) Usually of prolonged character. |



D. General paralysis of the insane has been seen during pregnancy and some few cases of katatonia also have developed at this period. In all varieties the danger of infanticide and suicide must never be forgotten, nor the tendency for the mother to falsely accuse herself of wrong doing and usually to show violent dislike to her husband.

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## CHAPTER XXV

### INSANITY DURING PHYSICAL DISEASE.

Formerly most writers used to make a special division of insanity with physical disease, and enumerate in particular insanity with gout, heart and renal disease, asthma, rheumatic fever, diabetes, chorea, myxedema, exophthalmic goitre, malaria, phthisis, suustroke, influenza and syphilis.

It must be allowed, and indeed never forgotten that tubercle, asthma, diabetes, chorea, exophthalmic goitre, myxedema, like migraine, epilepsy, hysteria, and alcoholism are diseases of the nervous heredity stock, that is to say, that in investigating the family history of insanes it is extraordinary how often one finds a history of these diseases with or without actual insanity having occurred in members of the patient's family; in other words, they are diseases the occurrence of which predisposes to the occurrence of insanity in the offspring.

Then, again, clinically insanity showing itself by a disordered mind, and this being dependent on a healthy brain which again in its turn depends for its nutrition on healthy blood and other body tissue, it is easily understood how, as everybody will allow, though the fact is almost always neglected, that every "bodily" (sic) affection is attended with some affection of the mind; such a trifle as a catarrh, an attack of dyspepsia or constipation will render anybody dull, lethargic, and apathetic, or incapable of thinking clearly, and it is only a question of degree between these, the restless agitation of a painful toothache up to the delirium of an acute disease which after all technically must be regarded as a variety of mental disease.

It is, however, more than doubtful of there being any direct connection when insanity happens during the course of the diseases above mentioned, or granting that there is, that there should be any reason why the list should not be extended to almost every affection of the human body. The mental symptoms when such coincidences

occur, are not so definite or distinctly uniform as to enable us to form even a clinical entity, nor is the association so frequent.

On the other hand, it is easily conceivable that in a person predisposed to insanity by heredity, and such is almost always the fact in these cases, that any one of these diseases may be the last "stress" or exciting factor in its production, while in many the insanity is obviously of the nature of an infection or exhaustion psychosis producible by almost any acute affection. Separating such cases, the numbers of actual association of insanity with this or that "physical" (sic) disease and the number of these showing any uniformity of symptoms dwindle down to zero, and it is only the special reference made by writers, the popular belief of some, and a few isolated facts that warrants one in noticing individually these associations.

There is, however, certainly a direct connection between mental affections and diseases of the thyroid, tubercle, chorea, sunstroke and syphilis; in all the others, the occurrence must be regarded when not of the nature of an exhaustion as purely a coincidence.

Diabetes, for example, though one of the diseases frequently found in the family history of insanes, has no direct relation, and curiously enough, though such a common disease in India, it is practically never seen in these asylums.

The same may be said of spasmodic asthma, though this is probably a nervous disease, and not at all uncommon among insanes. It then, however, is not more seen among one class than another, chiefly seeming to occur in cases of melancholia. Some writers describe the intensity of the asthmatic condition as alternating with that of the mental symptoms, but certainly no such instance has occurred here. Indeed, in all the cases, and there have been a good number, the two seem to increase *pari passu*.

Among Europeans in whom, of course, gout occurs though to a much less extent than at home, there is the usual feeling of depression connected with an undeveloped attack and irritability, with its acute form. It has been noted to cease when insanity supervenes, and return when this is past, and *vice versa*; but a direct connection of the two diseases is more than doubtful, and the affection possibly as a result of their dietary has never come under my notice among natives of India.

Heart diseases bear also no definite relation, though insanity occurring in the subjects of aortic regurgitation is said to be

usually of the type of acute mania, sometimes with great exaltation of ideas, somewhat resembling cases of general paralysis rarely of the type of agitated melancholia, while melancholia is usually described as accompanying mitral disease. Mitral stenosis is in my experience usually accompanied with a fretful complaining disposition and often with hysteria.

The occurrence of insanity in persons suffering from kidney disease is very rare and uncertain, though renal disease is found among every variety of chronic insanes. Those unfortunate insane beings, so common in India, who habitually eat mud in large quantities, and who become progressively anæmic and feeble and finally die as they always do, with general anasarca and diarrhoea, always show *p.-m.* a condition of kidney resembling large white. They are nearly always demented or chronic maniacs. This particular affection is still under investigation.

Rheumatic fever has been said to alternate with insanity like gout, diabetes, and asthma, while the delirium of the fever may pass into mania, and the illness itself be followed by a post-febrile psychosis, or, according to Savage, by a change in the capacities and moral qualities of the patient. It is, however, a disease that is not common in India, and gives no examples of insanity, at least in my experience.

There is, however, a direct connection between affections of intellect and diseases of the thyroid, as evidenced by the condition known as cretinism, and that of myxedema and the rarer association of insanity and exophthalmic goitre.

Cretinism is an endemic disease of mountainous districts, associated with atrophy of the thyroid, though this itself has been supposed to be due to disease of the parathyroid.

Sporadic cases are, however, seen all over Europe and occasionally met with in India. The disease, one of early child life, is a result of atrophy of the thyroid, though this may be subsequent to congenital goitre, or the gland may have been congenitally absent. The result is a condition of imbecility associated with a bodily change so striking in character as to render it very easy of recognition. The child is stunted, squat, with large head, short thick neck, broad sunken nose and large ears. Thickened coarse yellow skin (always singularly dry and devoid of perspiration), which in places may be seen in folds or even pendulous masses, and over each clavicle as soft shapeless tumours. The thyroid cannot be felt. The fat heavy cheeks, the thick everted

lips, and large clumsy tongue and defective teeth, with the coarse scanty black hair, and the large protuberant abdomen, and short stunted limbs make up the whole a hideous dwarf, who adds as additional drawbacks to his appearance, his defective speech, often consisting only of some inarticulate sounds, his slow, tottering gait, clumsy, awkward movements to the general dulness, stupidity, and want of intelligence, which may vary from complete and helpless idiocy to mild imbecility, this latter being the condition usually seen in the sporadic cases met with in India.

The disease is, however, very amenable to treatment, with some or any preparation of thyroid, continued small doses of which usually rapidly effect a marked improvement. It must be remembered, however, that the remedy will have to be continued throughout life, as failing doing so, the child at once rapidly reverts to its original condition. An analogous affection rarely seen in India, also associated with failure of the thyroid gland, but in persons previously healthy, is that known as myxedema, a condition always accompanied with more or less of mental affection. It is most frequent in women (the proportion being 10 to 1 in the opposite sex) and occurs usually between the ages of 30 and 35. Such people undergo a remarkable and characteristic bodily change. The skin becomes rough and dry, waxy, yellow and curiously swollen, an œdematous condition which does not pit on pressure, though it is to a slight extent elastic. Sweating is impossible. As a result, the face becomes remarkably round, puffy, with thickened lips, nose and eyelids, so that the patient has a look of sleepy stupidity, which is heightened by the monotonous tone of voice, slowness of speech and movement. The fingers and hands become puffy and shapeless from the "solid" œdema, while the hair and nails become coarse and brittle, and the tongue thick and large.

The temperature is subnormal, so that there is always a feeling of chilliness. The pulse is slow, and there is anæmia, constipation, amenorrhœa, and rarely some hæmorrhages from the mucous surfaces.

Mentally, with the progress of this condition, there is a steadily increasing weakness of intellect; not only are all the impressions from the skin and special senses slowly and imperfectly conducted, the sight and hearing weakened, but general apprehension is very defective; the patient becomes slow in understanding, deliberate to exasperation, in thinking, speaking and acting he cannot grasp

the meaning of what is said or done around him; the memory becomes feeble, he makes mistakes, cannot fulfil his usual occupation, and spends the day lethargic and half drowsy, trying to keep warm, fatigued and depressed, full of vague fears at his condition, which he can usually well appreciate. The lethargy is in some occasionally broken for a short time by fits of incoherent talk or letter writing, fleeting hallucinations of sight, delusions (started no doubt by their own chagrin at their facial appearance) that people stare at them; insult them, while still more rarely intervals of mild excitement and exaltation are met with, and in others delusions of injury and hallucinations of hearing. If left untreated, such a patient rapidly becomes profoundly demented, but like cretins, they are capable of being practically completely restored to health again by the regular administration of thyroid gland extract; this however should be commenced in small doses, and then must be still further decreased. if any symptoms, such as greatly increased heart's action, faintness or giddiness, or very rapid loss of body weight show that this is necessary.

A certain small number of patients are admitted into Indian asylums with insanity, supervening during the course of exophthalmic goitre, or rather, it is best to say as the history given is always so meagre and unreliable, that the two diseases are co-existent. This is not the place to discuss the pathology of this malady, of which the cardinal symptoms, the enlarged thyroid, the rapidly pulsating heart with or without a murmur, the tremor and exophthalmos with retracted upper eyelids, the flushing and occasional diarrhoea are the same all over the world.

Mentally, the condition usually seen is one of mild maniacal excitement; the patient is restless, sleepless, chattering incessantly, and refuses food and clothing; almost invariably there are hallucinations of vision complained of; he or she sees frightful forms; a "faqir" comes to them at night, assumes then the form of some horrible bird or *bhut*, and periodically annoys them. Following these hallucinations, the condition may change a little, and fear and depression alternate with general restlessness and agitation.

In our experience here most of these cases with rest, careful feeding and attention slowly recover. If drugs must be given, a preparation of Belladonna, regularly administered, is the only one of any service. Recovery is usually attended simultaneously with a marked decrease of the exophthalmos and rapidity of the heart's action.

Some anomalous cases, with simply the enlarged thyroid of long duration and rapid heart's action, are seen with a certain amount of weakmindedness plus impish behaviour and impulsiveness, with a general incapacity to follow any occupation ; such also complain of visual hallucinations similar to those just referred to, but they do not usually recover.

Two or three cases of insanity have been seen here with very rapid heart's action, 150—160, some tremor of hands and eyes, of which all that can be said is that they seem a little more widely open than those of most people. The mental symptoms are, however, not uniform, sometimes resembling mild melancholia, and in others the condition being one of excitement. Such cases recover mentally, though the heart's action often remains much higher than normal, 100. It is difficult to know how to exactly class them.

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## CHAPTER XXVI

### CHOREA.

Chorea is one of the maladies frequently found to have occurred in the near relatives of insane patients, and is also not uncommonly met with in early life history of people affected with insanity, while it is, though more rarely, seen simultaneously with or following and during mental disease, in which latter case it is usually noticed among women and is then extremely chronic and practically incurable.

As regards insanity supervening on chorea, it must be remembered that, in this disease, there is necessarily always a certain amount of dulness, defective attention, listlessness, and loss of memory, and that varying degrees of this may appear while well marked actual insanity is relatively more likely when the chorea occurs in pregnant women, or in an attack that has been preceded by several others. The restlessness and loss of muscular control always seen, if progressively increased and attended, as it often is, with persistent insomnia and restless agitation, may pass on to mania of an exhaustive type with clouded consciousness and hallucinations of hearing and vision, while in others a variety practically indistinguishable from acute delirious mania with raised temperature, great excitement, and motor restlessness, refusal of food, and inability to sleep, has been recorded ; the combination of this with the chorea, in itself a very exhausting malady, is extremely likely to be fatal.

It is the acute types of chorea which are most likely to be accompanied by insanity, and it is rare for this complication to arise in any subacute form that has already lasted over three weeks. Pregnant women, suffering from chorea, may on the other hand become melancholic as a result of the combined effects of the exhaustion induced and the mental anxiety and depression, while others again develop ideas of persecution.

In some rare cases the mild mental change always noticed in this disease passes on to stupor, after which mental recovery is unusual, as these patients generally become completely demented.

The treatment of the insanity is that of chorea in which disease there is always great disturbance of general nutrition, weakness and loss of body weight, so that this resolves itself into giving large quantities of nourishing food at regular intervals, stimulants and forced feeding being resorted to on the slightest difficulty, while suitable measures must be used for preventing the patients injuring themselves by their constant movements, the most efficacious for this purpose being the placing them on a mattress on the floor with others around them. Absolute rest is essential ; they should not be allowed to walk about.

#### HUNTINGDON'S CHOREA

There is met with under this name a chronic progressive hereditary disease of distinctive character and which, though not tending to shorten life, is quite incurable.

It affects people of middle life between 35 and 45, and is handed down by both males and females for several generations, and is always attended with a steadily increasing weakness of intellect, which always ends in profound dementia. Such a person, with such a family history, begins gradually to suffer from chorea usually first in the face ; this spreads to the arms and all over the body ; though at first the movements are somewhat under control ; they soon cease to be so, and though at first these cease during sleep, later they are continued even at that time, and there is a peculiarly spasmodic halting gait spoken of as being characteristic.

Coincidentally with the chorea the patient becomes apathetic, listless and stupid, to a certain amount depressed and emotional, a condition which may be broken by periods of slight excitement, when he becomes irritable and fractious. Rapidly however he loses all volitional power, all initiative and capacity for judgment

and memory, and ultimately passes into a condition of absolute dementia.

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## CHAPTER XXVII

### TUBERCULAR DISEASE AND INSANITY.

Phthisis, as at home, is a very common disease among insanes in India, and especially in the Punjab, possibly the frequency here being explained by the easy means the ever-present dust so characteristic of this province affords of carrying the dried sputum; also there are more particularly the filthy habits of so many insanes here of eating mud and dirt, their utter neglect of cleanliness, the custom they have of lying on the ground in all weathers, and when ill, of spitting in every direction, and all over walls and on their blankets, etc.

Its onset is extremely insidious; these people cough but little, their mental symptoms mask the physical, and therefore suspicion of its existence should always be aroused if a patient persistently loses weight, and has an evening temperature; even then it will be frequently overlooked until very late, for auscultation of Indian insanes is most difficult. There is a noise all around, the patient himself will not sit up nor keep still nor silent, and the attendants are of course useless in aiding one.

It is curious that there should be at first little cough or expectoration; hæmoptysis, and that fatal, has been known to occur here in a patient in whom the existence of the disease was quite unexpected. In many after a short illness a chronic and intractable diarrhœa rapidly exhausts the feeble vitality still left in them, and a fatal syncope occurs.

All cases of tubercle in the Punjab are rapidly fatal, and such patients ought to be rigidly segregated, and whenever a patient is brought from any room, or building shared by others, all the clothing and bedding of all in it ought to be disinfected, and the patient's clothing and bedding kept rigidly apart from that of others. The area inhabited by tubercular patients must be entirely grassed, and on no account kept "leaped" or bare.

Apart from its common incidence among insanes, tubercle has also a very important relation in some way, not very clear, to mental disease. In examining the family history of such patients it is astonishing in what a large number tubercle has occurred in some near relation. The union of a person who has a strongly



marked hereditary tendency to tubercle with another who is "neurotic" or of neurotic heredity is extremely likely to be followed by insanity in the offspring.

It is, however, also supposed by many that a certain type of insanity arose in patients suffering from phthisis, and in England a special variety almost of mental disease of this description has been described, in which (though curiously the ordinary person suffering from phthisis is most remarkably hopeful and sanguine, always, however ill, declaring himself certain of rapid recovery); these later patients gradually alter, become melancholic, suspicious, obstinate and irritable and quarrelsome, refuse their food, declare that they are "unworthy" or that poison is being mixed with their nourishment, etc., and develop various delusions (arising probably from their altered feelings) that they are being poisoned and persecuted. It is said that with consolidation of the lung there is usually refusal of food; whereas when this latter breaks down and excavation follows, there is a return of appetite; also that a serious hæmorrhage or rapid increase in the lung disease may be followed by a mitigation of the mental symptoms, and also that just before death sanity often returns.

No such cases ever come under one's notice in an Indian asylum, though, as before said, tubercle is fairly frequent there, as is this disease occurring in people already insane, when it then attacks any variety of such; but it is an extremely rare, almost unknown, thing for a patient to be admitted here with insanity which has developed subsequent to the commencement of the phthisis. The explanation of this no doubt is simple: tubercle is not a very common disease in the country, and when it does occur, is of very rapid growth. Few patients survive six months from its commencement, and the vast majority, at least in the Punjab, do not live four months.

#### MALARIA AND INSANITY.

Malaria is very frequently credited with producing insanity: it is, of course, as is well known, by far the most frequent disease affecting insanes in this country, but then it is that of the ordinary population, and in an institution well drained, where accumulations of water are not allowed, and good arrangements for clothing and warmth are made, the actual relative incidence may be as in this asylum actually less than that of the surrounding population. There is, however, this peculiarity, that an acute

attack, especially in cases of chronic insanes, is very liable to cause rapid prostration ; it is no uncommon thing to find a patient of this class after an attack of ordinary ague almost pulseless, and all such cases need most careful nursing and attention. Unlike some other acute diseases, such as pneumonia, carbuncle, acute dysentery, etc., it is never noticed to cause a rapid amelioration in the mental symptoms ; indeed, on the contrary, repeated attacks are very potent in increasing the amount of dementia. The cases where mental disease is said, as it is by some authors, to replace and intermit with malarial fever, must be extremely rare, for such has never been noticed in the Punjab, though it is true that the intensity of the prostration and physical illness of an acute attack may, while it is on, mask the mental symptoms. In cases of malaria in ordinary people with a very rapid rise of temperature to a high degree, the patient may become delirious, and if of neurotic stock, wildly maniacal with visual and auditory hallucinations, and then become rapidly semi-unconscious or comatose, but such a condition may attend any high temperature from any cause and is not peculiar to malaria. Cases without hyperpyrexia may become semicomatose, and die in that condition in some of the "malignant fevers" of malaria of the æstivo-autumnal type, and sudden delirious apoplectic-like conditions, aphasia and convulsive seizures, have been also seen in severe types of this disease, and these have been described as presenting *post mortem*, a condition of "embolism by the malarial parasite of the capillaries of the various nerve centres." These however are all rare ; and such cases do not enter an asylum. On the other hand, what is not at all unusual, is for a person usually of neurotic family history to be attacked with malaria of a severe type ; he lies ill, usually unfed, neglected by the poor ignorant family of which he or she is a member, and when the "fever" passes off, if they live, the patient is brought suffering from a typical exhaustion or post-febrile psychosis, restless, chattering, with clouded consciousness, disoriented, careless of dress and cleanliness, refusing food, and utterly prostrated and feeble ; such cases unfortunately are frequently only brought after some interval during which they have been allowed to be untreated and neglected, most usually tied down to a *charpoy*, filthy and half starved from their refusal of food, and many arrive after all these active symptoms have passed off, and they are left in the condition of less troublesome but hopeless dementia. A certain number with good feeding and nursing make a good and

rapid recovery, but these are few, and only those who are brought soon after the onset; the larger number recover temporarily and then after an interval relapse again, the acute symptoms pass off and recur again after an interval; a few then recover, but many become chronically insane with more or less dementia. On the other hand, a patient may arise from a severe attack of malaria after a prolonged convalescence, during which he has been lying at his own home, improperly fed and cared for, practically demented, his memory almost lost, foolish and stupid, dull, wanting in intellect, initiative or volition, unable to care for himself and frequently wet and dirty. Such cases also are often not seen until after some prolonged interval and are then practically incurable.

#### INFLUENZA AND INSANITY.

Of late years the frequent occurrence of influenza has caused great attention to be paid to this disease, and it has been shown in Europe that some affection of the nervous system is peculiarly frequent after an attack; indeed, almost every possible disease of the nervous system from neuritis to abscess of the brain has been recorded as following it. As regards mental diseases, in predisposed people during the febrile stages, an attack of mania may arise, though this is rare and what is more usual is for an attack of melancholia to develop a short time after the cessation of the malady, the onset of the latter bearing a direct relation to the amount of sleeplessness and loss of appetite and weight that so frequently follows influenza, and in any neurotic patient great attention should be paid to these symptoms, in order to obviate the possibility of such arising. The melancholia in these cases has nothing distinctive except perhaps that there is a great danger of suicide. Recovery is very frequent, though a few cases with persistent hallucinations of hearing sometimes become very chronic.

No case of insanity in connection with influenza has come under our notice in this asylum, though the disease is fairly often seen and is frequently followed by the neuralgic headaches, sleeplessness and headache so often noticed elsewhere.

#### SYPHILIS AND INSANITY.

Syphilis, though a most important cause of disease of the nervous system, does not often bear a direct connection with insanity in India. The para-syphilitic affections, indeed, as is well known, never occurring among natives of the country.

Also despite the opinion apparently prevalent elsewhere, syphilis itself is not a very common disease among natives of India ; when met with, it is, as is natural, most prevalent in large cities, whose inhabitants, after all, form a very small proportion to the total population of the country, while it reaches its minimum in the country districts and among the higher caste Hindoos everywhere among whom it is in my experience extremely rare, and as a singular proof of the tendency to simulate the vices of civilisation, it is, like alcoholism, most frequent among the best educated, the Babu and subordinate official class of the community.

As a result of the vice of sodomy so common in asylums here, this disease is not unfrequently seen among patients already insane; in them it runs its usual course, though usually it is of a severe type; but it does not in my experience materially influence the course of the insanity; several cases have been seen here to make good recoveries mentally, while suffering from the disease; while on the other hand the severe cachexia and general ill-health it causes, may in others seriously increase the tendency to dementia.

Pathologically, the syphilitic virus, as is well known, affects the nervous system by—

(1) Causing a specific obliterating (as it is often termed) endarteritis, producing a diminution of the calibre of the vessels and consequent thrombosis and softening, in this case affecting most frequently the basilar vertebrals, and the middle cerebral and its branches.

(2) By causing a gummatous meningitis, local or general, and the formation of gummata on the surface and in the substance of the brain. Both these varieties (1) and (2) being usually combined.

(3) By causing a chronic progressive degeneration the para-syphilitic affection. Unlike the more common first two affections which are relatively most frequent in the first few years after infection, this third is a later affection occurring from 6 to 12 or even 20 (?) years after. The examples of it are, of course, locomotor ataxy and general paralysis of the insane.

*It is these forms of syphilitic disease which are unknown in India*, though they may be seen in Europeans who have been even long residents in the country.

Though syphilis has no direct influence in the production of mania, melancholia or chronic delusional insanity, the syphilitic

ulceration and disfigurement resulting, together with the very natural self-consciousness of this, may be the final exciting cause in disturbing the balance of a "neurotic" person; or apart from this, it is conceivable that the onset of this disease so dreaded by all may be the last straw in the production of mental disease in one predisposed to it, and given the two diseases together, *i.e.*, insanity and syphilis (not a common combination in India at all), the symptoms caused by the existence of the latter may be used as a basis for delusions or hallucinations. The patient presenting his sores and eruptions as a proof of the injuries he believes to have been inflicted on him, or if a melancholic, claiming them as evidence of his sinful and hopeless condition, or if a paranoiac, interpreting his optic neuritis, palsies, etc., as a proof of the justice of his delusions of suspicion, though as locomotor ataxy is unknown, we do not meet here with the insane interpretation of lightning pains, etc., seen in Europe. A well-marked form of obsession is known, in which the patient has a constant dread of infecting everybody with syphilis, is always washing his hands, clothing and eating vessels, etc., but this syphilophobia, as it is termed, can scarcely be claimed as directly due to the disease. It is in any case very rare in this country, and the condition of melancholic depression and remorse as a result of his conduct and its consequences also described is practically unknown. Though a hypochondriacal form of melancholia, where the patient, though quite free from it, is convinced that he has contracted the disease and is always showing some trivial abrasion or discolouration as a proof of it, is on the contrary occasionally met with. It however presents in itself beyond this fact nothing distinctive from other types of this affection.

In Europe the fever that may attend the acute onset of syphilis has been described as rarely passing into an attack of acute mania, but such has never been noticed here, and practically and clinically, the influence in India of syphilis in producing mental disease may be restricted to—

(1) Its effect in the production of idiocy.

In this particular too syphilis, though a possible is not a common cause of idiocy in the offspring; it is said to be most potent when the mother has become infected during her gestation.

The form of idiocy produced has nothing distinctive, except in those cases in which blindness or deafness as a result of con-

genital syphilis, as so frequently happens in this country, gives examples of idiocy by deprivation.

A large number of cases of idiocy met with in India in an asylum are varieties of cerebral diplegia, and in the causation of this disease syphilis is believed to have a large share, a fact standing in marked contrast to those of infantile hemiplegia with epilepsy and weakmindedness, also so frequently seen and with which syphilis seems to have no casual connection.

Lastly, syphilitic disease in children is almost always the cause of idiopathic hydrocephalus by the production of a cicatrix that blocks the ventricular channel: this, however, is not a disease usually admitted into asylums, in this country.

(2) In the production of syphilitic organic dementia which is clinically the most frequent of all the associations of this disease with insanity.

This occurs either secondarily to thrombotic hemiplegia and cerebral softening, to the formation of a gumma or of gummatous meningitis when its symptoms are those of ordinary organic dementia, or without these from a pure form of syphilitic dementia which is very often determined by some injury to the head, or some acute "stress" which seems to form the last straw in lighting up the latent possibility in a man who has suffered from syphilis some years previously. Such a patient becomes progressively weakminded, degenerates morally and socially, he loses his memory and is unable to follow his occupation; usually from the onset he is markedly irritable. This slowly increasing state may be interrupted by intervals of excitement with grandiose ideas, assertions of possessing great wealth or power, or he may have in this connection hallucinations. Those who do not finally become very stupid, almost stuporose, with no knowledge of time or place, unable to recognise where they are or who are about them, may sometimes develop delusions of persecution, while an uncertain number linger for an indefinite period, indolent, apathetic, useless and incapable, foolish, wet and dirty for years. In all forms the mental apathy, the passing of fæces and urine under them is an early symptom. At any period the existence of severe headache at night, with perhaps palsy of some cranial nerves (a very rare event in ordinary insanity) may be the first clue to the syphilitic origin of the dementia, and such a symptom should never be neglected, as very early treatment with large doses of iodide of potassium or sodium, with or without

the addition for a short time of mercury, may sometimes effect a rapid cure. More often though, unless a gumma is the active factor in the disease, all treatment is unavailing, though curiously enough, intervals of intermission are sometimes seen, when the patient appears to rapidly recover; generally and most often only for all the symptoms to rapidly again recur and to end in complete dementia.

(3) The para-syphilitic affections, the progressive chronic affections, *i.e.*, general paralysis of the insane both of adults and in the juvenile form. Neither of these ever occur in natives of India, though they are seen among Europeans here, and therefore a brief description is appended. A certain number of the cases of dementia (syphilitic), with thick blurred speech, unequal pupils and optic neuritis, might be mistaken for such on superficial examination.

#### SUNSTROKE AND INSANITY.

“Sunstroke” or insolation is popularly supposed to have an influence in producing insanity. In this country, when, if that were correct, one would have expected to see innumerable examples, for the disease is very frequent, such a connection is, to say the least, uncommon and instances of its unmixed causation still more so. In the asylums at home one is sometimes shown examples in people who have returned from India. I feel sure, however, that most alienists will support my contention, that in many of these, if not in all, there are strong grounds for believing that alcoholic abuse far more than the insolation has been the most potent factor in producing their mental disease. It is exactly people of such habits who are most affected by exposure to heat.

In India where the entire native population is daily exposed to the sun, though I must own that they are just as careful in their efforts to avoid (as are the Europeans) subjecting themselves to it more than is necessary, it is incredible that were its influence unquestionable, it should be not more prominent, but while “sunstroke” is common, insanity attributed to it is very rare.

It is believed also popularly that continued exposure may without producing active illness bring about a slight weakness of intellect, and in particular a partial temporary loss of memory. The evidence for this too is not very conclusive, as most of the examples cited are in people in whom the combined effects of overwork, ceaseless worry, ill-health from many other causes have

coalesced to produce a condition of general bodily enfeeblement, quite capable of accounting for the mental incapacity which is at its worst relatively trifling.

Sunstroke or heatstroke or insolation is a generic term for at least three distinct diseases, or we may say clinical entities, of which I know no more clear or graphic description than that given by Sir Patrick Manson in his work on Tropical Diseases.

(1) There is a heat exhaustion, really a syncope, resulting from exposure to high atmospheric temperature. Nearly always this, however, is only potent on account of unsuitable clothing that impedes respiration or a state of bodily exhaustion or disease, fatigue, or ill ventilation, and above all alcoholic excess. Failing any of these and given free ventilation, a very high temperature can be endured with impunity. The kitchen of one jail, under my charge, was for months at a temperature of  $125^{\circ}$  nightly. No cases ever occurred there, though one died in a crowded neighbouring barrack, and at the same time corpses used to be removed daily from the crowded houses in the narrow stifling lanes of a huge native city close by.

In this variety of the disease the man is pale, with cold skin, subnormal temperature, sighing respiration, small, feeble pulse and dilated pupils, and is like all people fainting, quiet, or semi-unconscious. The majority recover under the treatment usual for syncope.

(2) A condition of hyperpyrexia, coma, and extreme pulmonary congestion, very fatal, coincident at least with high temperature, though it has been suggested by Sambon, that this really is a germ disease by some organic agency requiring a high temperature for its development.

Like No. 1, this also is powerfully predisposed to by bodily disease, bad ventilation, fatigue, tight clothing, malaria and intemperance, especially by the two latter, and also, like heat syncope, it does not occur in temperate, healthy people, whose respiration is not impeded by improper clothing or who are in well-ventilated places; also it is very variable in its incidences; it may be epidemic, it terminates often by a critical sweating and leaves curious sequelæ, neuritis for example, all facts strongly suggestive of the germ theory; as also is the fact that it is often preceded by curious prodromata, irritability of the bladder, cessation of sweating, pains in the limbs, vertigo, headache, intolerance of light, suffused conjunctivæ, nausea, etc. While its onset is always



attended with total insensibility, laboured stertorous breathing, flushed cyanosed face, usually contracted pupils, hot, dry skin, a temperature of perhaps even 108, a rapid, feeble pulse, subsultus tendinum, restlessness or even spasms and convulsions.

The mortality among Europeans is at least 25%, and among natives very much higher.

Many such cases have come under my notice, but none have shown subsequently any mental symptoms other than the temporary natural, mental and bodily exhaustion which always follow any case of high temperature and severe illness.

(3) Sun traumatism.

In this a variable number of cases are those of extremely sudden death while actually exposed to the sun's rays, apparently from paralysis of heart and respiration. It is also supposed to be predisposed to by tight clothing impeding respiration and to be not due solely to the high temperature, but to some direct influence of light; it must, however, be remembered in this particular that no atmospheric temperature in the shade ever equals that recorded under the direct sun's rays.

Besides the cases of sudden death, there are others of rapid fever, plus severe headache, full quick pulse, intolerance of light, sound and movement, dry skin, vomiting and delirium. Some of these cases recover, others persist for long, with feeble health, and all are liable to be followed by loss of memory, tremors, amblyopia, deafness, very persistent headache and, it is said, by epilepsy and insanity. Many of these cases, even after apparently perfect recovery, are unable to bear the least heat or sun exposure without a recurrence of their symptoms, and most are, as is well known, peculiarly susceptible to the action of alcohol, the smallest quantity at once producing pronounced drunkenness. It is these cases which practically are the only ones bearing any relation to insanity; there are, however, one or two points worthy of mention before discussing their influence as they tend considerably to complicate the subject.

(a) In the first place, many cases, formerly attributed to the "sun," were undoubtedly instances of severe malaria with hyperpyrexia, and a few others were cases of pneumonia and other diseases of rapid and insidious onset.

(b) There is a curious connection between malaria and sun heat. In a person who has suffered from malaria, the least exposure to the sun, if unprotected, will frequently bring on an attack of it (ague), just as it is well known that almost any disturbing influence, expo-

sure to cold or a wetting, and indiscretion in diet, will in such people have the same effect, the "sun" is given greater prominence in this country because it is always with us. It is this reason and the extent to which everybody practically in India, Natives and European residents, are saturated with malaria, that renders the question of the direct and unassisted action of the sun a very complicated one.

Practically, its influence in producing insanity may therefore be restricted to those cases in Class 3 from which may result—1st, a form of organic dementia technically identical with that following traumatism, to which insolation is for all clinical purposes identical. The patient is left after recovery (sic) "changed," foolish, timid and depressed, incapable of working and thinking as before, irritable, even violently passionate over trifles and peculiarly susceptible to alcohol or to the least exposure to the sun, incurably altered, the different examples varying from fairly complete weakmindedness to simply a moral and social change in the ego, or little more than a liability to intense fits of anger, this form of weakmindedness being peculiarly marked by a great susceptibility to fatigue and forgetfulness.

2nd. With a change more limited to one department of mind. A striking deficiency of memory for past as well as present events, or a purely social moral change. In all varieties a curious peculiarity is a great liability to sudden exacerbations of the symptoms and also for them to be attended by failing eyesight with very little change in the fundus oculi to show for it, although sometimes the pupils are unequal, a diminution of the power of hearing and persistent headache, or headaches that recur at intervals, or patches of paræsthesia, tingling or numbness down the area of root distribution of certain roots of the spinal cord, and this latter is very typical, when the sun exposure has been on the back, as in cases happening while crawling in shooting (this symptom also, though it may fade away with prolonged residence in a cold climate, at once returns on the slightest exposure to the sun).

Examples of this affection, when all is said, are however not common, though even they are more so than the only remaining one to be described.

3rd. Like any other severe illness attended with high temperature, sun traumatism is liable to be followed by a post-febrile psychosis, very rarely, however, seen in the early stages, but usually coming under observation later, when the patient will be noticed

to be restless and to complain of auditory, visual and sensory hallucinations; he sees faces, hears threatening voices, believes the ground moves, etc.; that people annoy, threaten, or molest him as a consequence; he is irritable, obstinate, subject to fits of violent rage on little or no provocation, is unmanageable and sometimes violent or even homicidal; sleeps badly and is in poor general health. The hallucinations in these cases often persist for some time, and though the patients usually recover to all appearances, they seem never quite the same again; they are altered, have not their former self-control, and are always irritable.

The difficulty of obtaining clear histories in this country and the general unreliability of all evidence, makes it as yet impossible to say whether such cases only occur in people of nervous heredity or whether the dementia, for instance, is ever seen in others; the probabilities are strongly, in my opinion, that such is possible. Of one fact we may at least be certain that the total number of cases showing undoubted connection between mental weakness and insolation is very small, and that, given temperate habits, sensible clothing, protection to the head, and what is equally to the purpose down the spine, the danger is relatively infinitesimal in the open air; and that when such an association is claimed as an explanation of the cause of a patient's insanity, it is always necessary to very carefully eliminate the equally potent factors of alcoholic excess and malaria; and less often excessive fatigue and predisposing ill-health before one agrees to the conclusion offered.

#### HYSTERIA AND INSANITY.

Though there is certainly no such disease as hysterical insanity, most writers devote a chapter in works on mental disease to the conjunction of these two affections, between which there is an undoubted relation. In almost all cases of hysteria (over 80%), there is, as in insanity, a strong neurotic history. Of two members of a family, brought up it may be under the same conditions, one may become insane, the other an hysteric; hysteria and epilepsy in the parents may be followed by insanity in the offspring, or insanity and epilepsy in the parents by hysteria in the children, while a person who has been "hysterical" in early life may become insane years later, and in short, practically the same hereditary and exciting causes may produce it as mental disease.

Unfortunately the subject is obscured by the fact that the "laity" and indeed some medical men very unjustifiably use the

term hysteria to include various nervous and mental diseases difficult of explanation, and many others also from that incomprehensible, though widespread idea, that the possession of mental disorder implies a disgrace not only to the unfortunate sufferer from it but to their relatives, who willingly seek to disguise the fact by styling any variety of insanity, especially in young women, as hysterical. As a matter of fact, hysteria, though from increasing knowledge of neurology, its term is becoming more restricted is a definite disorder, with definite physical and (like all such) also definite mental characteristics to itself; curiously enough it is very rarely seen in an asylum, but at the same time, though unlike every other variety of insanity, its mental characteristics are of such a nature and so very constant as to leave no doubt that technically all cases of the disease show a disordered mind.

The essential mental peculiarity of an hysteric is a morbid self-consciousness (I mean here that state which is intended popularly when one speaks of a "self-conscious" person), a craving for sympathy, which leads them to exaggerate their ailments or even to malingering or manufacture symptoms (though the latter fact does not affect the reality of the existence of the primary disease), an excessive emotionalism, all symptoms which are the antithesis of those met with in true insanity.

This is not the place to attempt a description of hysteria which Mœbius is cited as regarding as a congenital morbid mental state, in which diseased conditions of the body are produced by ideas usually of an emotional and indefinite character. It may be here pointed out that it is not, as commonly supposed, confined to females, and when met with in childhood, is indeed more common among boys, and that though most common in early life, it may be met with at any age, and its occurrence does *not* bear a constant or prominent relation to disease of the sexual organs.

While memory, apprehension, and intellect are quite unimpaired (as regards memory see later), the patients exhibit a deficiency of sound judgment, which leads them to be easily attracted by anything new and sensational. The emotions are markedly uncontrolled and liable to frequent and abrupt changes; they will laugh one moment and cry the next; they are subject to hypochondriacal ideas and exaggerate any feeling of discomfort, concentrate all their attention upon their own ailments, are exacting and selfish in their demands, markedly self-conscious, constantly seeking and demanding something new, dilate on their sufferings,

though always ready to be interested in any object of self-enjoyment. They are markedly impulsive, giving way to sudden erratic ideas, so that their conduct is unstable, and it is not possible for them to follow any prolonged occupation, and all are peculiarly mendacious and mischievous. Some few talk of suicide and even make foolish absurd dramatic attempts, though true endeavours for that purpose are most rare.

The physical symptoms are endless, and, indeed, simulate almost every known nervous disease, though they are characteristic in not following any known anatomical and physiological rules.

The most common are convulsions simulating epilepsy, but more prolonged not attended with, unconsciousness, nor the involuntary passage of excreta or any self-injury, and being accompanied with struggling, attacks on bystanders and the assumption of curious attitudes, functional paralysis and contractures of limbs, anæsthesia especially hemianæsthesia with anæsthesia of the special senses on the same side, obstinate vomiting, anomalies of respiration, loss of sight of one eye or of hearing of one ear, restriction of fields of vision and of colour areas, adductor palsy of the larynx causing aphonia, and rarely aneuria. The common sensation and special senses even unknown to the patient, almost always showing some perversion. Sometimes there are "dreamy states" in which the patient lies quietly with relaxed muscles, eyeballs turned to one side, a condition interrupted from time to time by slight convulsions, and from which they may be aroused by a sudden sharp stimulation, or sometimes there are attacks of somnambulism, or states of ecstasy with visual hallucinations of a dramatic character. There is always a tendency to romancing and exaggeration in the patients' description of their sufferings and experiences, and curiously enough memory for the periods of convulsions or for other portions of the malady may be completely lost; the same may also be said of the somnambulistic state in which a woman especially may wander about, do abnormal foolish acts, steal, set fire to furniture or other articles, go naked, etc. As regards the more definite mental disorders associated with the disease, the excitement and emotionalism of a lengthened attack may pass on into a maniacal delirium, or this may simply assume the form of acute mania with various symptoms of hysteria superadded, and except for a tendency to spiteful behaviour, for the patient to be extremely decorative, and perhaps a greater tendency to visual and auditory hallucinations, plus the special

history of the patient, there would be nothing absolutely characteristic. The majority of such cases make a good recovery though some few of them become demented.

It should never be forgotten that the greatest care must always be taken in examining persons with hysterical symptoms to exclude the existence of disseminated sclerosis and cerebral tumour, and in Europeans commencing general paralysis of the insane. Careful attention to the fundus oculi and to the condition of the reflexes should be sufficient. No mere hysteric ever has optic neuritis or an extensor response or loses the knee jerks, or shows electrical degeneration of the muscles, while, on the other hand, the grouping of the symptoms in hysteria has a peculiarly bizarre, anomalous conjunction that is in itself characteristic.

Hysteria is not a common disease in India and its conjunction with insanity is still rarer. Some few cases of mania are seen in which the patients also exhibit symptoms which in Europe would be regarded as of an hysterical nature; usually any clear previous history of the patient has been quite impossible. I have also seen an undoubted epileptic, whose fit sometimes alternated with what appeared to be prolonged functional convulsions, in which she fought, struggled, and bit, and which soon ceased when left alone, but I could never quite convince myself that these were not really simply epileptic automatic acts, and the patient one night suddenly committed suicide without ever having previously spoken of such a thing. Broadly speaking, this is one of the diseases whose existence among natives of the country may be ignored, at the utmost its symptoms, and that very rarely may colour other ordinary mental affections. When met with, the obvious indications are good nursing with regular and plentiful food; and above all, removal and seclusion from friends. The exciting cause is usually a moral one, some form of worry, and if this can be removed, which is usually almost impossible, a speedy and complete recovery can confidently be expected.

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## CHAPTER XXVIII

### DELUSIONS.

A delusion is an untrue belief of the falseness of which a patient cannot be convinced by argument or by experience.

As a delusion is always in reference to the self, for that reason it is never a matter of indifference to its possessor, and frequently influences his emotional condition. Though some may appear to arise from a false interpretation of an actual occurrence, it is obvious that they do so from an insane interpretation and inference from the same, and for this reason cannot be overcome by an appeal to experience, so that they may be said to be due essentially to an impaired "functioning of judgment and reason." *Defendorf*, p. 37. Yet it must be owned that marked mental weakness, such as congenital imbecility, never is accompanied with delusions.

On the other hand, as in health, when enthusiasm and excitement may create temporary hopes, fears and beliefs, always of the self, that fade away with the resolution of the emotional state into its normal condition, so in insanity a morbid emotional tone, in itself a result of loss of higher control, may have, at any rate, a strong influence in the production of a delusion originating most easily during periods of depression or excitement. But then, on the other hand, it is to say the least curious that they should appear in some cases of *Dementia Præcox*, in which there is no display of emotion nor any clouded consciousness, and still more so that it is exactly the most systematized unshakeable delusions that are stated by patients in a clear, calm, self-possessed manner. While if we regard them as solely due to weakened power of judgment and recovery, it is to say the least curious, that they should not be seen in idiocy, simple, senile or organic dementia, or why the true paranoiac should appear at least to have in other respects these faculties quite unimpaired. Their method of production is, therefore, not certainly known.

It is not easy where exactly to draw the line clinically between an idea or feeling of exaltation or depression, and a delusion, at least when the patient expresses his feeling in words.

As regards undoubted delusions, however, it is possible to claim that some originate purely in ideas, those of self-accusation or depreciation, but in by far the largest number of cases, it can be shown that the delusion arises (1) from a false interpretation of a real occurrence, of which all cases of paranoia give example, the delusions of persecution, or hypochondriacal delusions in the same way form a misinterpretation of some feeling of bodily discomfort and so on ad infinitum, or (2) failing this, it will be seen that they arise from an hallucination, so that in either case we are led to

the conclusion that it is a defect in judgment and reasoning power, which is the essential factor or in their production.

There is, however, a group of cases in which they seem to bear a direct relation with the emotional state, in that they seem to change with this and to disappear on its cessation; the best examples of this are some form of Dementia Paranoides; such are, however, fleeting and changeable, and for systematized elaboration of the idea a calm unimpassioned condition of mind is, as in health, essential.

In delirious conditions delusions are seen dependent on, and coincident with, the hallucinations of the senses always met with then; they are fantastic, changeable and fleeting, and disappear usually when the delirium subsides, just as do those coincident with an emotional disturbance. If as, however, sometimes happens, they subsist after the other symptoms have ceased, there will always be found that a certain amount of mental weakness has supervened.

Delusions with hallucinations are almost invariably seen in all insanity of a toxic origin, but delusions are also met with in almost every variety of chronic insanity except congenital idiocy, moral imbecility and some form of simple, senile and organic dementia. They are also not seen in simple mania, nor in recurrent simple melancholia. They are not met with in impulsive insanity and they are very rare in epilepsy and hysteria, and what is most important to remember in this country, is that though very common in chronic mania they may be totally absent in those most dangerous (usually homicidal) cases of Chronic Melancholia which show a tendency to outbursts of ungovernable rage on very trifling provocation.

When present in other varieties, they often assume a character typical of the disease as in delirium tremens, where they are of a terrifying nature of being tortured, worried by persons and insects and reptiles, and are then in direct relation with the characteristic hallucinations.

Alcoholic Delusional Insanity has the typical coherent delusions of persecution of very rapid onset, based on hallucinations of hearing, while the Alcoholic paranoiac shows the gradual onset of delusions of marital jealousy without hallucination in this case accompanying them.

In the initial delirium of Typhoid the patient exhibits quiet delusions of poisoning and persecution; he hears distant relatives talking around him, while in the post-febrile psychosis the patient



is quite disoriented, complains that he is being shaken, that corpses are around him, that he is annoyed in various ways, at the same time his speech becomes confused, incoherent, and he exhibits the symptoms of general bodily weakness and prostrations just as are seen in a pure exhaustion psychosis, in which there is perhaps more defect of attention. Such, however, and the remaining are referred to under the special varieties of insanity they accompany.

### HALLUCINATIONS.

Hallucinations can be defined as sense perceptions, arising without any recognisable external stimulus to produce them, a light or figure seen in an absolutely dark and empty room being the standard example, or a voice heard when to everybody else there is absolute silence. Technically an hallucination is distinguished from an illusion which latter is said to be an erroneous interpretation of a real sense impression; the imagining a shadow to be a person moving, etc., but it will be often found extremely difficult to satisfy oneself that an hallucination may not have had its starting point in an illusory interpretation of some obscure sense perception. Both are extremely frequent in Mental Disease, quite 80 per cent. of the patients presenting the symptoms the mere presence of which alone, however, it may be here added, is by no means an infallible proof of insanity. Many sane people have illusions, etc.; they may "mistake" as we say something they see for what it is not, but then they correct this and acknowledge their error by the evidence of the senses. We may imagine a shadow to be a person moving, but when we arrive there and see the reality, and find that there was not even a shadow, we acknowledge our error, whereas in an insane it is this incapacity plus the other symptoms always present which prove him to be mentally diseased.

An hallucination appears to arise from abnormal excitability of a cerebral sensory area, the same indeed aroused in ordinary perception, but like ideation, aroused by associational tracts and not by those of "projection." For some reason not clear it has such great sensory vividness as to be absolutely indistinguishable to its percipient, from an ordinary sense perception; that is to say, the person really does see, hear, etc., and for this reason it is, the owner cannot be reasoned out of his belief by any evidence of his senses, as his hallucinations are to him quite as vivid and real as any these give him, just as no logical reasoning will induce him to discredit

them. In this particular too that hallucinations are probably aroused from ideational tracts it must always be remembered, that an hallucination is a "memory" product; in other words, what a patient thinks he sees, hears, feels, etc., is a revival ideal, if one may say so, of ideas of something he *has* actually seen, heard, etc., just as in dreams, so a patient never has an hallucination of anything which he has not before experienced. A man who had never seen a ship or a picture of one, would never have an hallucination of such an object; indeed, if he had, it is difficult to know how he could describe it. There are, however, modified hallucinations described as psychic, pseudo, or apprehension hallucinations which are really extremely vivid ideas, *i.e.*, the patient himself can distinguish them, but the lack of intelligence and power of expression found in the ordinary villager who makes up the majority of the patients in an Indian asylum, does not usually permit this variety to be clearly distinguishable.

Hallucinations have also an intimate connection with the coincidental emotional condition, always being more potent and numerous if this is excessive.

It will perhaps be granted that an hallucination necessarily entails an insane belief in it, *i.e.*, a delusion, but it is equally certain that the presence of a most marked delusion as in early paranoia is quite possible without an hallucination.

Hallucinations may be of any sense, those of hearing being the most common; the patient declares people shout at him, abuse him, call to him filthy words or orders (it is extraordinary how rarely is anything pleasant heard) or he hears whistling cries of birds, pirs or faqirs exhort him, curse him, etc. Sometimes he simply complains of voices deprecatory or annoying without claiming that they belong to any special person, or he believes that the voices are internal to himself; and that by this means all his thoughts are read, etc.

They may be on the other hand visual; most frequently these occur at night, and though they may be met with in other forms of insanity, their presence is very suggestive of a toxic or drug origin for the malady. The most typical form of this being of course in Alcoholic Insanity, Delirium Tremens, where hallucinations of loathsome vermin, serpents, etc., are always met with.

Tactual hallucinations are more common than are usually supposed; persons complain that people pinch them, prick them, pour fire on them, tamper with their sexual organs, etc.; women

complain of snakes in their hair. Any cutaneous irritation being generally of an unpleasant nature, these patients are usually very vindictive and revengeful, and, taken broadly, are always dangerous. Though drug insanity usually results in visual hallucinations, it is noteworthy that the characteristic ones met with in cocaine poisoning are tactual, sensations of sand under the skin, tingling and irritation. Gustatory hallucinations are fairly common; that the food is poisoned, has filth mixed with it, that dirt and kunkur are given them instead of it; most of these are obviously cases of illusions and not hallucinations at all; in any case the belief in them is often the cause of refusal of food. Olfactory hallucinations are rare; they are usually, unpleasant and are supposed by Savage to be closely connected with uterine and ovarian disorders.

Hallucinations of all the senses together imply very extensive and serious cerebral derangement, while persistent hallucinations even of one sense, if they cannot be resolvable into peripheral sensory irritation, usually indicate Chronic Mental Disease.

In regard to their distribution in the various kinds of insanity Hallucinations are never found in idiocy, imbecility, weakmindedness or moral imbecility. They are not met with in pure impulsive or obsessional insanity, nor in the early stages of paranoia, being in that disease a late and subsequent development, their arrival indicating the stage of absolute incurability. They are also not seen in the intervals of the fit in Epilepsy, though often very complicated ones may immediately precede the onset of a convulsion as its aura, and though illusions are said to be frequent (*Kräpelin*) except before and after an attack of grand mal, such are not noticed in this country.

They are also unknown in Organic Dementia from traumatism, though they may rarely be seen after insolation and in cases of cerebral tumour. They are very rare in General Paralysis.

In Melancholia of the simple recurrent and agitated variety hallucinations are unknown, and the occurrence of such with symptoms of depression in a case is almost certainly indicative of it being one of Dementia Præcox and not melancholia. This symptom in this connection is most important and should never be forgotten. An ordinary simple case of melancholia never has an hallucination. Some few cases of pronounced delusional melancholia may be met with in which the patient declares that he has felt a bullock cart go over him, or that a faqir has cursed him and ordered him to die in

so many days, etc., etc., but even these, on close examination, will show simply a delusion, and no true hallucination, which is a symptom in my experience never met with in this disease. In senile melancholia they are, however, sometimes met with and are of very bad import. On the other hand, in regard to those in which they are present—

1st.—*In Mania*: Simple mania is never accompanied with hallucinations; they may, however, be found in acute mania, though they are then very fleeting and temporary, rarely of an annoying character or elaborated, and the same may be said of recurrent mania.

In acute delirious mania, hallucinations of all the senses, and especially of sight, are very common, numerous and persistent, usually accompanied by fleeting dreamlike delusions; they see fire, faces, figures, horrible scenes, hear fire roaring, cannons booming, beasts howling, their food tastes and smells badly, horrible animals crawl over them and so on *ad finitum*.

2nd.—*Dementia Præcox*: In this disease at the commencement senseless delusions of a silly character plus numerous hallucinations, especially of hearing, are very characteristic; these are usually accompanied at the onset by depression and fear. The hallucinations are peculiarly silly and absurd, and generally as the disease progresses clear up or are unheeded.

3rd.—All the senile insanities, the confusional condition, the senile delirium and the very rare condition of presenile delusional insanity, in which fleeting changeable delusions of persecutions are met with may, however, be accompanied with hallucinations of sight and hearing.

4th.—It is especially in the delirium of fever the exhaustion psychosis that supervenes on some acute febrile or exhausting malady, and the insanities from the use of drugs, that illusions and hallucinations of all senses constantly present, yet of varying character are met with, and their appearance is very characteristic. In the insanities accompanying peripheral neuritis (Korsakow's Disease) they are very particularly so, and in company with the fabrication of memory elsewhere described make an unmistakable picture.

In the acute confusional Insanity (Meynert's Amentia) from exhaustion with its sudden onset of confusion, disorientation and numerous hallucinations of all the senses, and rapid cessation

after a deep sleep. The whole forms a clinical entity that cannot well be otherwise than characteristic.

The insanity (acute furious mania) following excessive indulgence in Indian Hemp which is such a common affection in this province, is attended with very vivid visual and auditory hallucinations; usually the former have a sexual import; the man declares that beautiful women, Devatas, etc., visit him at night; the descriptions given by these men bearing a wonderful similarity. Very many, however, are so furiously maniacal, violent and incoherent, that it is not possible to obtain any details from them, and on recovery there is, as is well known, complete loss of memory for the acute period.

The visual hallucinations of Delirium Tremens need not be again referred to. In alcoholic delusional insanity, characteristic auditory hallucinations are met with, forming the basis of their coherent delusions of persecution, voices call after them, detectives and police follow them; with these visual illusions and hallucinations are also common; the latter, however, are most frequent at night, when ghosts appear, specks and insects float about in front of them. These with the very characteristic delusions that they are "wanted" by the police, and the remarkably clear coherent speech and consciousness and the history of alcoholism with its attendant muscular tremor, failing appetite and disturbed sleep make up a very characteristic associational whole.

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## CHAPTER XXIX

### THE EMOTIONS IN INSANITY.

An instinct which is really nothing more than a compound reflex action, resulting in what seems to us impulsive action, is usually defined as a faculty of acting in such a way as to produce certain results, without foresight of the end or previous education in their performance. An instinct shades imperceptibly into an emotion, only that these latter differ from instinct in that the emotional reaction usually terminates in the subject's own body as an organic change, with a strong and characteristic element of feeling resulting therefrom, whereas an instinctive reaction goes further, and enters into some practical relation with the exciting object. Also an emotion, though it may be aroused by a peripheral sense impression, is more often started by a percept or idea of some situation or

incident, and as we say has often no obvious practical dealing and may be excited by the mere memory or imagination of the object.

Emotions are also sometimes described as complex feelings with changes in the secretory organs and involuntary muscles, and an emotion is sometimes styled vaguely a feeling just as by others its extreme is termed a passion.

A weaker emotional state of somewhat persistent duration is usually spoken of as a mood.

Nesting is a common example of instinct in animals, sucking in the human species, while the series of emulation, rivalry, pugnacity, anger and fear shew the gradation of instinct into emotion. The whole subject is lucidly treated in that wonderful work of Williams James, the Principles of Psychology, where the same author shews that the feelings characteristic of each emotion are a result of the bodily changes, typical of each one and not *vice versa*.

It has long been recognised that there is a necessary antagonism between intellect and emotion; in other words, as every one will own, if we feel strongly on a subject, we are incapable of judging fairly on it. The slightest introspection will convince us of the intimate connection between our bodily health, the condition of our viscera, and our emotions and state of general feeling; an overloaded stomach and an indigestible meal will produce a feeling of depression and a dose of calomel or a stimulant, when such is needed, will produce as much excitant effect as good news or a pleasurable sense impression.

As the standard of emotion and general feelings vary with the bodily health and one's individual peculiarity, it is not possible to fix a normal one, though a very marked difference to what is usual is very easily perceptible. According to Stoddart J. of M. S. <sup>492</sup> No. 218 the motor paths carrying the response to a stimulus causing an (reflex) instinct or emotion are those in man, of the representation of the primitive system found in all animals below mammals in whom the pyramidal motor system is absent, *i.e.*, the corticorubral system of fibres the rubro-spinal tract (Monakow's bundle). The voluntary control being exercised by the pyramidal tract. This explains the well-known fact of the "emotionalism" always so marked in ordinary hemiplegia, Bulbar Palsy and disseminated sclerosis and General Paralysis of the insane. Without going into the question of causation, one may say that the emotions are

also uncontrolled in congenital imbecility, hysteria and during convalescence from Exhausting diseases, while the same is seen in conjunction with a definite fundamental emotional tone liable to rapid variation in the excitement of Mania.

For some reason for which one can offer no adequate explanation, with the fundamental emotional tone of gloom and fear in Chronic Melancholia, there is met with a constant tendency to outbursts of rage, on what, to observers, are trivial excitation or indeed sometimes when these seem totally absent.

Instincts and emotions being so low down in the scale of intellectual evolution, explains the fact that can be easily verified that emotions persist in extremely advanced mental deterioration. I have seen patients with combined alcoholic and epileptic dementia wet and dirty, absolutely devoid of any recent memory, and having lost that for events of the past 40 years, and devoid of all evidence of volition, still shew outbursts of rage and grief when some stimulus seemed to arouse their fading recollection, and the same can be seen in ordinary dementia after mania or melancholia. In more advanced cases the condition certainly is one of apathy. The persistence of one morbid emotion is very common in insanity, fear and gloom in melancholia, irritability in epileptics. Fear in some sufferers from obsessions, marked feelings of pleasure and excitement in alcoholic mania or ordinary mania, though these are also attended with loss of emotional control and as a result show great changeability. Temporary changes of this nature being also seen in alcoholic, morphia, and cocaine intoxication, and markedly so in hemp drug poisoning.

There are, on the other hand, conditions of insanity in which the emotions appear dulled and at any rate do not respond to strong stimuli, that in an ordinary person would cause a marked display of such. This is seen in some cases of melancholia and stupor when a patient may hear news of the most affecting and important matters without any obvious change; particularly is this to be noticed in Dementia Præcox, in which general apathy and loss of interest in anything and everything is perhaps the most marked feature, while the same is very obvious in Senile Dementia.

Perhaps this is also the place to note that some of the general feelings relating to self-preservation are also altered in insanity; maniacs are notably unsusceptible to fatigue, a fact which accounts for the exhaustion caused thereby; in imbecility and chronic mania

the feelings of nausea seem at any rate to be perverted, for such patients, as do some demented and general paralytics, swallow filth and earth. Persons with Melancholia and depression present every symptom of intense weariness, without obvious real exhaustion, and on the other hand in Delirium and exhaustion psychosis there may be exhaustion without weariness, and certainly we can only imagine this in cases of stupor and melancholia, and say of mania in which food is refused that the feelings of hunger must be greatly in abeyance.

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## CHAPTER XXX .

### MEMORY.

“Memory” which is practically essential for all higher intellectual activity, really includes under the term, the power of (1) receiving an impression of the senses and (2) retaining the same shown by the power of recalling past events. One of these capacities may be affected without the other. Every sense impression that we are conscious of, and there is some reason to suppose that even this consciousness is not always necessary, leaves a potentiality, a possibility of its recall either voluntarily or by association, and this is what we understand by memory. It is not a “faculty” or “power” located in one portion of the brain, but a property of certainly every projection area of the cortex; that is to say, there are memories of sight, hearing, taste, smell, muscle and skin sensations, and without these, perception and ideation would be impossible.

The individual power of memory varies widely in each person and in addition impressibility is also dependent on clear apprehension and active attention, and lessened when these are deficient. The power of receiving a new impression, of remembering anything, is therefore diminished by failing comprehension, indifference and distraction, so that it reaches its lowest point (being nil) in coma; it is little more in cases of clouded consciousness, weakmindedness and still more in cases of simple fatigue and exhaustion, when, as everyone knows, it is difficult to remember clearly. As regards insanity and its relation to memory, it is scarcely necessary to refer to the common error which associates loss of memory always with Insanity, such being absolutely untrue. Some imbeciles indeed present examples of extraordinarily powerful memories of a



specialised character. Some will, though unable to read a line of music, play through correctly any air they have once heard. Another, as I have seen, utterly unable to care for himself in any way, had an extraordinary memory for dates and would give the hour, day of the week, and date of any event that had occurred in his experience years previously, and such instances are very numerous. Still the large majority of idiots and imbeciles have none or very little memory, and for that reason are incapable of education.

In all acute insanities, except those of toxic origin, memory is very little if at all impaired, the patient frequently on recovery retaining an accurate knowledge of everything that had occurred, and this is especially noticeable in cases of stupor.

In Dementia Præcox, until the final stages of absolute weak-mindedness set in, memory for recent events remains extremely good, though with the onset of actual dementia it begins to fail. In cases of charas toxic mania and indeed acute intoxication from any drug, memory for the time of the illness is absolutely blank. In the cases of exhaustion psychosis, of acute delirium, of acute febrile psychosis, there is also no recollection of the time of the illness, and some curious cases of this nature are seen when the acute symptoms have temporarily or permanently subsided, and yet the patient has no idea of where he is, does not know his own name and is found wandering about, absolutely unable to give any account of himself, and with no recollection of this period on recovery. Such cases when not epileptic, are in this country usually the result of Indian hemp, or follow after an acute illness, or some other cause of exhaustion or a great shock, and may be looked upon as of the same nature as acute dementia, which is also attended with loss of memory. The same of course, as is well known, attends every epileptic attack, and the condition of epileptic automatism. These cases have a considerable medico-legal interest, as numerous crimes have come under notice of which the prisoners claimed they had absolutely no knowledge. When this plea is made, it will always be found that, if true, these patients are either epileptics, cases of Indian hemp insanity, or examples of insanity following a fever or some exhausting illness, or the crime has been committed during the delirium of the same. Two instances of persons with pneumonia left unwatched, and who have arisen, staggered out, and cut down the first person they met have come under my notice, but in these the history is definite; it is the others, before alluded to,

who appear calm and collected, in whom the difficulty of diagnosis arises and such are always one of the three varieties cited.

All Dementia is attended with failing memory, and this is especially seen in Senile cases, where the first symptom often is a failure to remember recent events; an old man will forget that he has eaten an hour before, and not know the doctor who visits him daily. The same occurs in organic dementia after paralysis, and in alcoholism, while in Korsakow's disease, poly-neuritic psychosis, the failure has also in addition the characteristic "fabrication" of memory, in which the patient gives calm, long-detailed accounts of events that have never happened.

All these diseases present examples of the loss of recent memory, that for past events being retained; the old man who cannot tell you at all what he has had for breakfast that morning, will detail with accuracy the events of his youth. This memory for past events can also be lost, for in some cases of severe head injury and cerebral hæmorrhage after recovery, it will be found that the patient has no recollection of events that preceded the injury, it may be for some long period. It is said that some people after recovery from attempts at suicide present this symptom, and I have seen some cases of weakness left after an exhausting illness, which also showed this peculiarity, while epileptics also in the epileptic somnambulistic condition which sometimes follow a fit, and in which they may go away for even months, have during that period no memory for the past whatsoever, nor do they remember this period on awakening, though they do recollect everything that preceded the fit. Such cases of loss of memory, of sudden onset, may be recovered from. In advanced senile dementia the loss of memory goes on extending further and further back until events of the past life are also forgotten, but this defect is incurable. Loss of past memory with retention of that for present events is possible. Cases of hypnotism are recorded in which the patient loses memory of the hypnotized interval on awakening, though on each fresh induction the memory of these past returns to him. Such however are not legitimate instances of insanity.

Some cases of paralysis may present in the various aphasias examples of partial loss of memory, and such are well known.

(1) A patient may be mind blind, unable to understand the meaning or use of any article he sees, though not blind, this condition is usually combined with word blindness; (2) may have

loss of memory for the meaning of written words, though seeing clearly figures, colours, etc., he cannot understand a single written word; (3) word deafness, though not deaf, he cannot understand anything that is said to him, and acts just as would a man in a land of whose speech he were ignorant. Aphemia when without palsy of lips or tongue, he has lost the motor memory for speech and cannot say anything, or agraphia where, though able to move the hand and fingers, he is unable to write: any of these examples may occur separately or in varying combination, and any or all of them are possible without paralysis in senile cases with arterial degeneration.

It is obvious therefore that there may be a failure of memory to continue acting or a loss of that already acquired, but besides this there may be a form of hyperexcitation or exaltation of memory, spoken of as occurring in acute fever and acute excitement, and which in all books is described as occurring with Hashisch poisoning. After a very careful examination of an enormous number of cases that have come under notice here, it has seemed to me that some mistaken inference has been made from the condition of mild excitement this drug causes, for this symptom has never been noticed though all "Indian hemp cases" are certainly disoriented and, as repeatedly stated, an absolute loss of all recollection of events for the period of intoxication is the fundamental and invariable condition. Hyperamnesia is also said to occur in those instances of persons who during fever, chloroform, Narcosis, etc., recollect languages long forgotten, or in those cases of persons saved from drowning who declare that during the period of impending suffocation they have remembered the events of their whole life, etc.

A third condition described as Paramnesia or illusion of the memory is when people believe that experiences quite new to them have occurred before in their recollection.

It is a rare condition having some analogy to the dreamy states described by Neurologists as occurring in lesions of the uncinate portion of the temporal lobe.

A modification of it is the fabrication of memory so typical in Alcoholic Neuritic psychosis.

#### DISORIENTATION.

By this term is meant that very striking symptom when a patient is unable to state where he is, and by whom, or by what

he is surrounded. Such a one will stare vaguely about, state that he is in some place several hundred miles away, or will simply own his inability to name the locality, he will have no idea that he is in an asylum, and can give no explanation of the people who are around him, and has no idea of time. It is obvious that by this is meant a different condition to that in which a man misnames places and people as a result of a delusion. Nor is the condition of coma in which the environment cannot be understood included either.

This condition does not necessarily follow on a disturbance of apprehension, *i.e.*, an inability to understand what is said to or done for him, though the two conditions are usually combined. It is most typically seen in Delirium Tremens, Exhaustion psychosis, the stupor after an epileptic fit, and in this country in Insanity from the use of Indian hemp, the senile confusion and delirium of old age and the insanity seen in some old people from arterial degeneration. It is seen immediately after injuries to the head, and though it is difficult of actual demonstration, it is undoubtedly present as a result of the hazy impressions and confused ideas found in acute mania, and still more in acute delirious mania. It is also present in complete dementia, whatever may have been the preceding condition.

## CHAPTER XXXI.

### SPEECH IN INSANES.

NOT only is the speech altered both in content, quantity and manner of delivery in insanity, but the articulation is, as is well known, changed in certain diseases met with in asylums. This is pre-eminently seen in General Paralysis of the Insane when it is peculiarly slurred and of a tremulous character, difficult to describe, but impossible to be mistaken by anyone who has once heard it. A very similar articulation is, however, occasionally heard in some epileptics in this country, but in these attention to the history of the patient, to the state of the pupils and reflexes, to the convulsions themselves and other sequelæ, the absence of the characteristic tremor or of the rapidly progressive dementia, and other mental symptoms serve easily to distinguish it.

In disseminated sclerosis, when any change of the speech is observed, the articulation is peculiarly scanning and syllabic, but the great emotionalism, the intention, tremor, and the other obvious symptoms of the disease are sufficient for its diagnosis. A very similar affection is, however, to be seen in people who have been for long addicted to the use of Sulphonal, and should always be remembered; it however ceases immediately the drug is relinquished, and is unattended with the other symptoms of sclerosis.

Before the onset of a fit or series of fits in Epileptics, the speech often becomes peculiarly whining and of an irritable character, that is absolutely diagnostic, and often after a fit it remains thick and slurred and indistinct, resembling that of a drunken man for some variable period.

Curiously, though stammering and stuttering is often found in the families of those insane, it is very rarely heard in an asylum. No instance of it there has ever come under my notice. A very fair number of insanes never speak at all, but maintain absolute silence, a silence that may be kept up for many years; generally this is the result of some delusion or hallucination, and there are nearly always many other obvious signs of insanity. We have now a man who has never spoken all the 17 years of his stay; he is clean, decent, quiet, but has a constant tendency to stab in the face with pieces of wood, sharpened bones, nails, in fact anything, and has several times effected his purpose; he writes what he requires and then explains his conduct as being in obedience to the order of a "murshid" who (he writes) nightly visits him and gives him instructions.

Another man maintained silence for 5 years, during that time always crawling on his knees. One day he suddenly began to walk and speak, but his language was so disconnected and incoherent, that it was never possible to understand his explanation. There are always several other similar cases.

A man in a condition of melancholic stupor, in addition to being immobile, and usually wet and dirty, and refusing food, is always mute and will remain so from 1 to 3 years, and very often this symptom is the last to go, persisting 6 months after he has begun to walk and eat, and otherwise behave naturally. Mutism is of course also characteristic of some stages of Katatonia.

In a fair number of idiots, language is restricted to a few words or to a senseless articulation of a few sounds, while others, "idiots by deprivation," are congenitally deaf and dumb. These latter in this country only come under notice when nearly adults, abandoned by their relatives and having, of course, received no training. Several of this character have been received here who shewed very fair intelligence, so that the appellation of "idiots" was very questionable in regard to them; they are, however, usually very passionate and with habits of stealing and lack of decency (this latter less commonly); these defects, however, could reasonably be referred to their total want of any training whatsoever, and their quickness, ability and general intelligence in other respects are so remarkable as to impress anyone. When it is remembered that every variety of aphasia may be present with retention of intelligence, and when both these conditions are contrasted with the perfect articulation and yet absolutely disconnected speech of most chronic maniacs, a strong presumption is afforded, either of speech not being so essential to the integrity of mind as is supposed, or that there is a higher level dominating ordinary articulation which is affected in pure insanity.

Some melancholics can, with great difficulty, be induced to speak, but when they do, their language is perfectly sensible; the patient may describe absurd delusions or give impossible reasons for his dejection and misery, but he does so in a perfectly coherent and sensible wording; some, indeed many, as before said, will rarely speak of their own initiative, and when questioned, will reply with obvious reluctance, and in a slow "retarded" manner, and quickly relapse into silence, but still all they say is sensible, though its content may be absurd and obviously untrue. Just as the vast majority of melancholics shew a retardation of speech and thought, so when they become stuporose they cease to speak at all, while on the other hand in *Melancholia Agitata* the speech (sic) may be limited to groans, moans, or some other ejaculations. The speech is also perfectly sensible and often very natural in a paranoiac, and even when he describes his delusions, he does this in the language of a sane man; he reasons correctly from wrong premises, and distinctly sensible speech is also characteristic of moral insanity, impulsive and obsessional insanity, simple mania, and of many epileptics. In *Mania*, speech however is always affected. In the simple variety it may be only

very rapid, continuous and appears to be that of a plausible, vain, self-confident, rather exalted person, but every gradation is seen in this to the more acute variety, acute mania, where it is typically rapid, loud and incoherent, but this has been already discussed at length in the description of that disease, and need not be here repeated; the speech in this case is, however, never absurd if one may term it so, and when a man states grotesque nonsense to you, you may be sure that he has passed into the chronic stage of mania, and is unlikely to recover. In the chronic maniac, speech is either of this character or is a meaningless chatter, eminently disconnected and incoherent, even if such a one commences to answer a question perfectly; after a few words he follows the impulse of a new idea, and changes the sequence, so that in most it is impossible to understand it, and conversation is impossible, while in others of less pronounced exaltation, it is rapid, incessant, and wandering from subject to subject, usually interspersed with frequent reference to their delusions or to some hallucinations; as they become more demented, the difficulty of maintaining any conversation or of even obtaining an answer to a simple question becomes more evident, until in the final stages it is impossible to retain their attention and it becomes a senseless chatter, and still later practically ceases altogether.

Close observation of insanes, and insane families, creates a strong impression that a tendency to rapid incessant increasing talking, however coherent it may be, is strong evidence of a neurotic family heritage, or of degeneration in the individual; still more so is this if the speech wanders from the point very rapidly, and is discursive.

The speech of a person suffering from *Dementia Præcox* is very distinctive and peculiar. A young man constantly posturing in silly attitudes, grimacing; for ever breaking into causeless laughter or chuckling or apathetic and helpless, and even sometimes in an advanced stage when they are constantly wet and dirty, will, if his attention can be sufficiently aroused to answer at all, speak perfectly sensibly and shew evidence of a clear train of thought.

Many, however, will speak still in coherent language as though playing the fool; they will mimic a whining tone; if English, imitate a cockney dialect, and shew considerable shrewdness in speech and repartee and in fantastic terms and words.

The contrast between the language and the general appearance and behaviour of a patient with this disease, is one of its most

striking peculiarities. Verbigeration is also said to be characteristic of some form of Dementia Præcox, especially of Katatonia; it is a monotonous repeating of some word, or sound, or phrase a great number of times. In some of these patients it is a very prominent and early symptom.

There are a few terms for various varieties and symptoms of insanity which, though not of universal use or acceptance, it is necessary for students and medical men in this country to be acquainted with, if only for the purpose of meeting the questions of Counsel and others in legal cases who sometimes suggest them. The most frequent of these is Monomania; this is a term formerly of wide acceptance referring to a partial insanity, a person being supposed to have his mind affected on one subject, or faculty (sic) without involvement of any others. Such, however, is not really possible, the interaction of all the divisions into which mind may be separated introspectively is so complete that it is impossible to have one seriously affected without an impairment of all the functions remaining. Various subdivisions were described.

(1) Intellectual Monomania, where a patient suffered from hallucinations, delusions, etc., confined to a single object or series of such, and otherwise reasoned, felt and acted like a sane person. This condition may apparently exist, but close observation will convince one that the whole intellect and volitional powers are always seriously affected. Such are usually chronic maniacs.

(2) Affective Monomania sometimes, also described as mania raisonnante, in which there is a total change of character and of affections without defect of reasoning power. Such cases are usually incomplete recoveries from former melancholia.

(3) Instinctive Monomania was practically synonymous with impulsive insanity.

According to Esquirol, each of these varieties might be accompanied with either exaltation or depression; if the latter, then they are also described sometimes under the head of Lypemania (practically melancholia); Lypemania raisonnante being simply that variety in which the patient had unusually clear insight into the absurdity of his own apprehensive depression; Monomania proper being restricted by others to partial (?) insanity with exaltation. Monomania or Folie raisonnante being practically "moral insanity."

Affective Monomania was also sometimes described by others as affective insanity, and then divided into impulsive and moral



insanity, it being said that in both the memory, judgment and language appeared normal, while the emotions or feelings only were affected; hence, also its alternative term of emotional insanity.

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## CHAPTER XXXII.

### CIRCULAR INSANITY OR FOLIE CIRCULAIRE.

UNDER this head has been described a variety of insanity believed by some to be a distinct disease, in which an attack of Mania is succeeded by one of Melancholia, and this in its turn by another attack of mania, or more commonly by a period of sanity at the expiry of which the regular cycle would again recommence; such attacks occurring for long periods, or more commonly with gradually lessening intervals of sanity, until the whole was terminated by dementia. Whether the condition is a special disease or no, the alteration of the two forms, mania and melancholia, has been often described, and such cases possibly form the basis for the new entity, maniac-depressive Insanity, instituted on the Continent. All that one can say, however, with regard to this country is that in India such a regular alternation must be of extreme rarity, and has certainly never come under my own notice; on the other hand, it is certainly possible, indeed very frequent (1) to see a case of mania, not of toxic origin, without this being followed by melancholia, runs its course to recovery; (2) to watch a case of mania continue in that condition and to become chronic and to last so for many years unchanged, while in the same way melancholia may exist unaltered. (3) It is also possible to see (though rarely) a case of mania occur in a person who has at some former time suffered from melancholia and *vice versa*, but no case of regular sequence has ever been observed in this asylum. Cases of mania are, of course, often seen, preceded at the outset by some depression, more or less pronounced, while during the course of the mania the uncontrolled condition of the emotions may, of course be evidenced by alternations of grief, rage and mild hilarity and recklessness, but no one seeing the former would imagine the patient to be even transitorily melancholic. Mania in all its varieties is peculiarly frequent in this country and in this province, but among all the many instances of it that have been treated here, no single one has exhibited such an alternation of

symptoms as to warrant its being considered as corresponding to the type of disease under consideration.

Terms less usually mentioned are—

(1) Sympathetic Insanity, when mental disease seems to be connected with some more or less distant organ having no apparent biological relation with the cerebrum (Hack Tuke, Dict. of Psych. Medicine). The subject of Insanity having an apparent relation with disease of some bodily organ, has already been discussed under Insanity with Physical Disease.

(2) Theomania, or religious Insanity, is a term sometimes applied to those conditions presumably of Chronic Mania, in which the patient has a delusion either that he or she is a personification of the Deity or is God-inspired.

(3) Remittent Insanity is a term applied sometimes to that condition in which a distinct remission of the mental disease is followed by an exacerbation of all the symptoms. It is scarcely legitimate to elevate it into a distinct disease, as there is hardly any variety of Insanity which may not show this peculiarity, though it is especially frequent in General Paralysis of the Insane, Dementia Præcox and Melancholia.

(4) Insanity of Negation is a term sometimes applied to some varieties of Melancholia, in which the predominant feeling is one of inability or dislike to attempt anything, food being entirely refused, delusion of having no stomach, no brain, etc., being permanent, or having no family, no friends, etc., not that verbal denial of everything is necessarily present. It is in fact simply Melancholia and nothing more.

(5) Oligomania is a synonym for Monomania.

(6) Mania of persecution is simply the initial stage of Chronic Systematized delusional Insanity (Paranoia).

(7) Aboulia is a term used to describe the inability some patients present to effect any voluntary action, usually associated with impaired sensibility and with general depression; they seem unable to form the necessary motor image of the voluntary effect required; it is the opposite of impulsiveness, is usually seen in Melancholia and is in no sense the Insanity of doubt.

(8) Anamnesia is usually considered as the recalling "to mind of phenomena which immediately preceded an attack of disease" (Hack Tuke); it is frequent in persons recovering from insanity, especially from stupor.

The list might be indefinitely prolonged, for the nomenclature of Insanity is enormous and shews no signs of ceasing to increase.

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## CHAPTER XXXIII.

### TREATMENT.

THE treatment of Insanity in the present state of our knowledge is not very satisfactory, and various other circumstances, especially in this country, reduce it practically to seclusion of the sufferers in an asylum, and the management of this so as to provide the greatest comfort to its inmates and to afford every facility for that restoration to mental health, to which in a considerable proportion there is a natural tendency.

It is of course useless in the present state of popular feeling to even advocate the obviously practical course of exterminating the malady (which could perhaps be effected in a generation), by the prevention of marriage of anyone affected with insanity, idiocy, epilepsy, syphilis, or a tendency to alcoholism or drugs, and our efforts at prevention are, therefore, reduced to the giving of advice, usually not taken, as to living under hygienic conditions, and in the young the avoidance of excessive over-study at the expense of their physical development, the insistence on their having sufficient sleep, the avoidance of fatigue, and the efficient training of them from early life in the habits of self-restraint, consideration for others, abstinence and continence.

In this country we are hardly ever called to see a patient in the initial stage (that in which any treatment is most efficacious) and it is still more unlikely for us to be afforded an opportunity of treating a patient in whom simply restlessness, irritability, difficulty in sleeping, and change of behaviour and manner are the sole indications of commencing mental disease; in such a case absolute rest, good feeding, freedom from worry and annoyance, would be of great benefit.

In the enormous majority we only see a patient when he is so insane, and has become so troublesome, that he is of necessity placed in an asylum to give security and freedom from annoyance to the sane population; even then, however, much can be done for the amelioration of many, and for the comfort and well-being of all.

The mere seclusion in an asylum is of itself of benefit and that for a very simple reason, that the insane can there do as he likes, and feels free and untrammelled ; he can shout, be restless, petulant, do the 100 things that in his own home he is constantly being restrained from, checked, and upbraided for ; also he is in a changed environment and freed from excitants to worry and anxiety. In others also the mere shock of entering into such an institution in those able to appreciate it, seems to excite a certain amount of self-control and improvement.

It is possibly for these reasons that so many soon after entering there commence to improve.

For some cases already enumerated such as those of Paranoia, Impulsive Insanity, etc., no treatment is of any avail, and one is, therefore, reduced to regulation of their living to ensure their comfort, attention to their diet, state of the bowels, etc.

For all acute cases the essential factor of treatment, and that without which no other is of any avail, is regular and ample feeding. In this we have one advantage in this country, in the universal obsession of all natives for milk, for even when a man, as they so often do, refuses food, he can frequently be prevailed on without difficulty to take this, while with still greater advantage it may be given in addition to the ordinary diet, which should always be of a most liberal character, or entirely substituted for it if he refuses the latter, but in any case food must be given and in large quantities, and at regular intervals. It is of course impossible to induce a native to take eggs and with many also meat, so that we are forced to substitute for these latter ghee and lighter farinaceous food, such as sagó, tapioca and rice. If milk alone is given, the absolute minimum per day must be 2 seers—64 ounces. When all food is refused, nourishment must be given through a tube, and refusal of the second meal ought always to be at once followed by this resource.

Food may then be given by either an œsophagal tube, but in that case a gag and several attendants are necessary, or preferably by a nasal tube placed down one nostril ; specially made tubes are provided, but in any difficulty a plain piece of India rubber drainage tube, small enough to pass through the nostril, can be used ; it must be oiled or dipped into the milk to lubricate it ; usually a blanket or sheet is passed over the arms and body of the patient to prevent resistance, or in case of excessive struggling he may be rolled in it (like a mummy). In this way patients here

have been fed daily and thus kept alive for 12, 18 and 24 months. Some writers warn against ulceration of the nostril, but that has never been noticed here, and the only objection to its use is that the calibre being so small, only fluid can be given, anything else blocking it. A practical hint may be here given—inequality of the face is extremely common in insanes, and often a tube will not pass down one nostril but will do so easily down the other.

For the sleeplessness, hypnotics, Sulphonal 15 grains (not repeated too often in a week), Chloral, usually most objectionable, Bromide of potassium, trional, veronal and many others may be given. In the very acute cases they are usually all of no service, and sleep is much more likely to be produced by a heavy meal or a warm bath than by any drug yet known. In the chronic cases it is another matter. For the restlessness and violence to those about him, the most efficient means of dealing with such is to simply leave the patient at large in the open air, the ideal spot being one grassed and with shade; if, however, he is exceedingly obnoxious and destructive, there is no alternative left than to confine him to a separate room. In a climate like the Punjab padded rooms are impossible, it is difficult to devise any form of mechanical restraint that is not open to grave objection, and the attendant staff is so limited in number, and of such inferiority of character, that restraining him by their aid is quite out of the question. It is, however, the utmost rarity for a man to injure himself, his energies being usually devoted to doing so to others, or to the destruction of property; and if he cannot be allowed to roam freely about, a separate room with a large amount of straw usually solves the difficulty, such cases being often the very ones that make an excellent recovery. Drugs are of little or no value in the treatment of restlessness, etc. Hyoscin hypodermically in doses of 1/120 grain will of course quiet him,—by paralysing the nerve endings of his muscles—but this is only restraint in another and more pernicious form; there is a tendency to syncope, the body surface becomes pallid, visual hallucinations are apt to be produced, perhaps for this reason the patient is thrown into a condition of great fear at the sight of the physician who gives it, and his chance of recovery is lessened—and, in short, the use of this drug is quite unjustifiable in any acute case—though for a chronic irrecoverable one there may be less objection. Bromide of potassium continued in large doses is sometimes recommended, but as a matter of fact, if an acute case does not

recover in a reasonable time under good feeding and nursing, it will not do so any quicker by the use of any drug yet known. Morphia is useless in mania—it is, however, sometimes of service in restless melancholics, but must then be given in large doses as before described. It cannot be too often repeated that it is astonishing what improvement may be effected, and how many cases will recover completely, simply from freeing them from annoyance and worry, by secluding them in an asylum, putting them under hygienic conditions of life and surroundings, and feeding them liberally and regularly. The provision for most insanes of some form of occupation is of very great service; it renders their days less monotonous, they are far easier managed and controlled, in many it gives an outlet for energy that would be otherwise directed to destruction and violence, and in my opinion is often of actual service as a means of treatment. With the utmost deference to those holding a contrary opinion, experience here with the enormous number of acute cases that come under treatment has convinced me that many of those acutely maniacal (especially toxic) are actually benefited if they can only be induced to perform some manual labour when, provided ample nourishment is insisted on at the same time, they rapidly become less violent and begin to sleep. Such a course is not suitable for those in a state of mania with exhaustion; the exceedingly violent and excited of course cannot be induced to fix their attention sufficiently, and but few melancholics will do anything, but with others, and with all chronic cases, as I have already said, it is of great service. Here all the clothing, bedding, etc., is woven and made up by insanes, and this affords every description of both light and hard labour suited to every variety and all ages, and a large garden absorbs the remainder.

At the termination of an acute attack, when the patient, for instance, is in a condition of exhaustion and feebleness, no labour should be allowed until the weight has risen completely, and all acutely insane should be medically examined when at work daily.

As regards the general management of an asylum, much depends upon its structural arrangement, which should be carried out with a view to the comfort of the patients. In a climate such as this, where with the natives most of the day is spent in the open air, the compound or garden is of the first importance, and takes the place of day rooms; it should be of ample

space, 1000 superficial feet per head being regarded as the minimum and if possible grassed and planted with trees.

Then, the weaker, more helpless patients must be protected from annoyance by the stronger and more violent, by having separate compounds for each, two others being required for epileptics and for convalescent patients, while the extremely filthy should be relegated to another separate garden, and the noisy and destructive to yet another. If these two last are placed at extreme corners of the area, the minimum of discomfort is procured for the rest of the patients.

A large hospital for those "bodily" sick, and for the acute cases on first admission to accomodate at least 20% of the total population, is also needed, and to these must be added separate enclosures for tubercular disease, for dysentery and for isolation of infectious maladies.

The dwelling accommodation should be for the very large proportion of a separate or at least cubicular nature for each, and on no account should any large sleeping rooms, such as one sees in some asylums for 50, be provided. All Epileptics, at least of the class received here, ought to sleep separately, all criminal insanes, all of filthy habits, all those who habitually ill-treat the others, and they are many, and all those whose troublesome customs expose them to the violence of the stronger, whom they annoy. Indeed, after having seen a white-haired man of 60, and a helpless filthy dement used as passive agents of sodomy, one is strongly of the opinion that all patients should have separate sleeping accommodation.

The method of supervision of insanes has an immense influence on their comfort and well-being; it is useless to hope for much tact and judgment from the class of attendant one obtains in India, though some of the older men attain a wonderful knowledge of their patients; but the medical officer should remember that Insanes, apart from the fact that they are suffering from the most dreadful disease humanity is subject to, and in proportion the more entitled to pity and consideration, are in the large majority perfectly capable of appreciating and remembering just, thoughtful treatment, that even the most insane is often grateful for a patient hearing even though it may be of a rigmarole repeated word for word every day, that they are best dealt with in the spirit of sane men, never given a promise that there is no intention of keeping, and that they

are perfectly able to appreciate constant urbanity, politeness, and straight-forward dealing.

The question of visits of relations often gives rise to much difficulty; in general, in the acute stages, such are always harmful, and the more so if great benefit has followed the patient's removal from home, and seclusion in an asylum; nor should one be permitted directly a certain amount of improvement has set in; it is best that this should be firmly established before any disturbing influence is allowed to affect him; the same remark holds to "a change;" a certain interval of absolute sanity should be allowed to pass before the patient is permitted to leave the asylum. As regards letters, if these are from the family and contain news likely to create anxiety and worry, they should be retained until after improvement; those patients able to write are usually keen on doing so, and their ability to produce a sensible letter is a very good proof of complete restoration to health.

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## CHAPTER XXXIV.

### • PHYSICAL DISEASE AMONG INSANES.

EVERY variety of "bodily" disease affects insanes, so that at least 17% are always in hospital; it may be stated broadly that diseases usually classed as Medical run a more severe course, are apt to be unsuspected at their onset and cause far more rapid prostration than among sane people, and as a whole are with more difficulty recovered from; while, on the other hand, injuries and wounds tend to heal quicker and better, and in the face of greater difficulties than in the case of the sane Indian natives.

We have seen here large sloughing sores, received as a result of self-injury in charas intoxication, from which the lunatic daily tore the dressings, replacing these with fæces, heal rapidly and perfectly.

Fractures which despite the incessant movement that nothing could prevent yet make good union. From the quarrelsome and violent nature of many of the insane Pathans here, and the large number of insane epileptics, fractures and wounds are very common (see note) and yet an imperfect union is almost unknown. Still, at the same time these statements require qualifying, for after some years' experience one learns to be chary of performing any operation on insanes; the attendants procurable in India are practi-



cally worse than useless, and the most carefully applied dressings are almost invariably removed, so that the wounds become rapidly septic.

Also from the filthy habits of the majority of the patients, their custom of sleeping on the ground, the smallest abrasion or breach of surface is apt to become infected, and to suppurate, and nothing of this character is too trivial to be left untreated; also helpless, quiet demented and others should be daily examined for any sore or ulcer, for such paying no attention allow flies to settle on them, and maggots may form in what was apparently a simple ulcer, and the same remark applies to any discharge from the ear or nose, etc., in such people.

Curiously enough, it would seem that a more serious surgical disease is more favourable as to its results than a slight one, probably on account of its greater pain and inconvenience, compelling rest and attention, while one less so is neglected by the patient who will, frequently scratching or touching it, infect himself in various other parts from the pus of any small suppurating area. From these causes lymphangitis and extensive glandular suppuration may result from what was apparently at first some trivial affection. For another reason, the diagnosis of this from plague, this possibility should be always remembered.

Erysipelas at least in this asylum is very frequent; it presents nothing peculiar in its type or course except that even the most severe cases usually, if well fed, make a good recovery. It is scarcely necessary perhaps to say that the clothing and bedding of the room or cubicle he comes from and in which he is treated should all be rigidly disinfected.

From a medical point of view Malaria is the most common disease. In a country like this where every human being in it must at some time have suffered from the malady, it is not surprising that fresh attacks should be seen in an asylum, yet it is wonderful how attention to commonsense methods of prevention can diminish its incidence. In an asylum like this, with pucca, *i.e.*, impervious surface drains, where the patients are well fed and clothed, the relative frequency of malarious attacks may be less than that actually present in the population of the immediate neighbourhood.

In the late autumn, usually the most unhealthy time of the year, a prophylactic use of quinine 10 grains, twice a week, is always given, and appears to be of benefit; the distribution should not be commenced too early, *i.e.*, until the rains have actually set in and the

period to be selected will obviously much vary in different provinces.

Pneumonia is a fairly frequent disease, and if one or two cases occur together is very liable to spread, for the patients soil their blankets with sputum, careless attendants neglect to separate these, and the habit natives of this country have of wrapping themselves head and all up like a mummy, in these tends to make its communication very easy. Whenever several cases appear from one section or sleeping place, a rigid disinfection of all the clothing and bedding of that particular part will generally cause it to cease spreading. 50% of pneumonia cases here, despite the most careful attention die; every clinical anomaly in their onset, course and symptoms will be seen, cases of very sudden onset with no fever, no cough or expectoration, others with rapid heart failure, others latent until a thrombosis of the pulmonary artery carries them off, are to be observed, and what is very common is to see a patient live through an acute attack, the temperature to fall and even then for him to die within the next 30 hours apparently collapsed. Extension to the pericardium should always be looked for.

Cases of localised empyema are sometimes seen, in which the condition is not discovered until a day or so before death, or even until the *post mortem*—the temperature is very variable and inconstant, and the easy diagnosis of malaria in any case of sudden fever is a source of great fallacy to an inexperienced Hospital assistant, and this disease as well as Tubercle should always be suspected in any case of failing health and nutrition not readily explicable—but its discovery is not easy, the patients as a rule can tell nothing, auscultation of an insane in this country in the midst of ever-present noise and uproar with a restless often chattering patient is attended with extreme difficulty, and a hasty opinion should never be given.

Chronic Dysentery, like Chronic Diarrhoea, is next to Malaria perhaps the most common ailment, and is incomparably the most common cause of death, frequently ending in pulmonary artery thrombosis. The sick lie about uncovered, remove all clothing given them, and the best of attendants here neglect to cover them, the patients frequently soil their food, eat filth and mud, reinfect themselves from their hands, and unknowingly do everything to aid their malady, from which, once well established, it is rare for any patient to recover.

Among Indian Insanes, for some obscure reason, an ever-increasing number, at least here, eat earth and many do so constantly, and in very large quantities, a habit from which nothing will induce them to desist. The result is a condition gradually produced, of intense anæmia, debility, later general anasarca, muscular weakness, persistent diarrhœa and ultimately heart failure. Death is invariable in about 12 months, examination of the blood and stools has been up to the present negative (except that in some cases Eosinophilia is present), that of the urine is impossible from their habits, and the only invariable condition found *post mortem* is a state of the kidneys. The disease is still under investigation.

Extraordinary efforts by confining them in pucca rooms, depriving them of all earth, have been tried, but the general health suffers from confinement, they substitute mortar for earth, or failing that, pieces of brick blanketing or in fact anything, and when allowed out, instantly revert to their former habits. Certain women, not insane, have the habit to a less degree and in them too the attraction seems impossible to discover.

An extremely common cause of death is thrombosis of the pulmonary artery. This is the final affection in many very different diseases, Chronic Dysentery, Diarrhœa, Pneumonia, Anæmia, indeed any condition of ill health. Death is of course sudden and characteristic. Thrombosis is, at least in one's experience in India, very common among insanes—thrombosis of the cerebral sinuses, of the jugular—even localised clotting of the External jugular and subclavian causing sudden and intense swelling of the arm and side of the chest has been seen.

It is of course impossible to discuss all the diseases to which such patients are subject, any and every one may be seen, generally it may be said presenting some unusual symptoms.

Amenorrhœa in women is usually said to be common in insanity in Europe, but after a lengthened experience here one can most emphatically assert that such is not the case among natives of this country, except in some few cases of Melancholia; what however is common in relation to menstruation is for all the symptoms of insanity to be much aggravated with its onset; on the other hand, profuse and prolonged menstruation, with an attack of acute mania, is very frequent at its commencement.

The habits of the people render it absolutely impossible

to obtain any information as to whether any disturbance of menstruation precedes the onset of insanity in native women.

I must own to having seen it among European Insanes who are of course very few in number.

The bones of some lunatics are especially liable to fractures from an abnormal condition of these structures. In cases of Chronic Insanity there is a tendency to absorption of their internal structure, the osseous material being replaced by an excessive deposit of fat. (It is however worth noting that the patients affected nearly always appear very thin.) The condition is especially seen in general paralysis, but is also very common in any form of chronic insanity. Especially in the ribs, the external surface of the compact bone is thinned and riddled with cavities, formed in this way by absorption, so that the whole bone is very porous and liable to break easily. (I have seen several ribs at once fractured on the first attempt at artificial respiration.) Examined chemically, it has been found that the ratio of organic constituents to earthy matter is much greater and that of lime to phosphoric acid is less than in healthy bones. Occasionally these changes are even found in the vertebral column, and a progressive diminution in the height of a lunatic may be noticed in consequence.

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## CHAPTER XXXV

### THE LAW RELATING TO INSANES IN INDIA.

INSANE persons are usually admitted to asylums in India under authority of Act 36 of 1858 (as amended by Act 16 of 1874, Act 18 of 1886 and 20 of 1889) by which asylums may be established by Government, or private asylums may be licensed. There are, however, at present no private asylums in the country. The Act is very clear and simple.

Under it the police may arrest all lunatics found wandering and all such persons who are complained of as being dangerous. They are brought before a Magistrate who, if a Medical Officer (usually the Civil Surgeon), certifies them to be insane and orders their removal to an asylum of the province. It is open to him, however, if his friends appear, and are willing to undertake (in writing) his care, to hand him over to their custody. The Magistrate may also if, it is reported to him, through the police, that a lunatic is not under proper care and control, or is being

cruelly treated, order the person bound to maintain him to provide for the lunatic's proper treatment, on pain, if wilfully neglected, to imprisonment for a month, or if he prefers it, may order the insane to be received into the local asylum. In Presidency towns the duties of a Magistrate are performed by the Commissioner of Police. If there is doubt as to the insanity of the person in question, the Magistrate may order his detention for 10 days' observation (extendable on Medical Certificate to 14 days) in an asylum—if sane, he is discharged; if found insane, the Medical Officer in charge signs a lunacy certificate and he remains under treatment.

In Presidency towns it is, however, permissible for an insane to be received under an order signed by a relative, supported by two Medical men's certificates. By No. 2263—80 Govt. of India Proceedings Home (Medical), Calcutta, 11th December 1900, Government Medical Officers are prohibited giving certificates of lunacy except when "required to do so by law," as for example under the above Act. This was afterwards modified in order to allow a Government Medical Officer to do so, provided he forwards the certificate to the asylum to which it is proposed to send the patient, and that if he is not received there, then the Superintendent of that asylum either destroys it or returns it to the Medical man who has signed it, *i.e.*, it must not be given to the friends of the patient.

It follows from this that it is not easy to put an insane patient into an asylum, except through the medium of the police (except in a Presidency town and even then some Medical man, not in Government service, must be called in). The difficulty is surmounted by private application to the District Magistrate, through the Civil Surgeon of the District; publicity and police agency being sometimes thus avoided.

Provision against illegal detention in an asylum is amply provided by a board of visitors, who inspect the asylum monthly, and are empowered to see every part of it, all documents and any 3 of whom can order the discharge of any patient at any time.

If a person is wealthy, it is provided under Act 35 of 1858 (amended by Act 14 of 1870) that the Civil Court of his district may, on application, institute an enquiry for the purpose of ascertaining whether he or she is of unsound mind and incapable of managing his affairs. Notice of the time and place must be given to the alleged lunatic, or if he is in such a state that this

would be ineffectual, the Court may direct a modified service. The Court, however, can always compel his attendance at any time or place, or if the distance of his residence is above 50 miles, may direct a commission to hold the inquiry.

If he is then adjudged insane and incapable of managing his affairs, his estate, if liable to the Court of Wards, is put under their care, or if otherwise, then of a Manager of the estate, who may be any near relative, or the Public Curator, and a guardian of the person of the lunatic, who must never be the legal heir, otherwise it is at the option of the Court to combine the two offices in one person. On any report, by practically any person that the lunatic has recovered, the Court may institute enquiry for that purpose, and if it agrees, may free him from control and deliver over his estate.

It would appear from this that the "guardian of the person" may order the detention of the insane person in a lunatic asylum.

All certificates of Insanity must be in the prescribed form A on the Schedule to Act 36 of 1858.

I, the undersigned hereby certify that I on the day of at personally examined and that the said is a lunatic and a proper person to be taken charge of and detained under care and treatment and that I have founded this opinion on the following grounds, namely:—

(1) Facts indicating insanity observed by myself.

(2) Other facts (if any) indicating insanity communicated by others.

Dated

Signed

An insane can be removed from one lunatic asylum to another asylum by order of the Executive Government, but to transfer him out of that Government to another requires the sanction of the Governor-General in Council. (1) It is of course open to the relatives of a lunatic wishing to avoid the trouble and delay of this proceeding to obtain the discharge of a lunatic from one provincial asylum and then take him to another and get him received there.

The Governor-General in Council is also empowered to make an asylum in another Government (more conveniently situated than that of the Government itself, *i.e.*, in area) to be the necessary asylum for certain districts. In this way the Insane from

the Western Rajputana States, Ajmere, and Bikanir are always sent to the Punjab.

In all Government asylums the charge of maintenance of every lunatic is one on the estate or the relatives—if these are unable to meet this, then the charge falls on the District Board, Municipality, or Cantonment Funds of his residence—should he have been found wandering, and be unknown, the charge is on the Funds of the particular District Board, Municipality or Cantonment whence the order for his admission was obtained.

A native military insane is subject to the same rules for admission as a civilian, after having first been discharged from the service by a Medical Board; he cannot now, as before, be placed in an asylum under Military authority; but this is still permissible with regard to British troops in the country in those asylums designated by Government as being one of these in which their reception is permitted. Army Regulations, India, Medical and Military Lunatics' Act (Act XI of 1897 and XVIII of 1894).

As regards Criminal Insanes in India, they are of three classes:—

- (1) Those unable to plead by reason of insanity.
- (2) Those acquitted on the ground of having been insane at the time they committed the act.
- (3) Those becoming insane during the time they were undergoing imprisonment after conviction.

The regulations respecting them are laid down in Act V of 1898, Chapter XXXIV, and in Act No. III of 1900.

The law in these respects, except as regards British soldiers, makes no distinction between Europeans or natives, but no European, if a pauper, will be deported to England unless it can be proved that his transfer would effect a cure or unless he has an "unquestionable settlement on the United Kingdom." In that case accommodation is occasionally provided by troopship.

For European lunatics, not a charge on the state and who have sufficient means, no legal mention is made; they can and are taken to England if the relatives desire it; the only difficulty in the matter being to induce a steamship company to carry them, and to provide for their care and nursing on board. Such are also very occasionally accepted on troopships.

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## CHAPTER XXXVI.

### DEGENERATION.

CERTAIN of the most common bodily peculiarities that are frequently met with among insanes have been already enumerated. These with some few others more rarely seen among them, *i.e.*, nutritive affections, such as, Acromegaly—plural births, hæmophilia—excessive fecundity, early *lipomatosis*—defect of bodily organs, such as deformed uteri, cloacal conditions, sexual deformities, horse:shoe kidney, cycloplan monstrosities, *Amelia and polymelia*, club feet (congenital), plural mammæ, abnormalities of the muscular tissue, etc., are usually classed together as evidences of nutritive degeneracy, or of local reversionary tendencies, or more often as *stigmata of degeneration*, a term which requires a little explanation.

(1) In the first place, one and all of these peculiarities are frequently hereditary (the fact that many of them are frequently so only through the female, is only an evidence of the greater influence on reproduction taken by the element of that sex, and does not affect the question).

(2) But all these stigmata of degeneration are found not only in every variety of insanity and idiocy but also in the hysteric, epileptic, the sufferers from many nervous diseases, the “neurotic,” the “one-sided genius,” the criminal, the prostitute, the pauper, those born blind and the congenital deaf mute and in those inheriting a tendency to Phthisis.

(3) While, on the other hand, each of the sufferers from any of these neuroses has usually a history of one or any of these affections in their parents, near relations or ancestors—a fact very clearly evident in the family history of the insane for example.

Now, whether we agree with Weisman or not, in his doctrine that external causes or “acquired characters” acting on the body cannot be transmitted to the offspring, at any rate it is a matter of common experience that at least some insane persons have had insane parents, that the union of two insanes is very likely to produce insane or idiotic offspring, that epileptics may have epileptic children, that some criminals are the offspring of criminals, etc., and *vice versa*; in other words, that marked tendencies can be, and often are, inherited and passed down. Also, there is very strong ground for the belief that a vitiated constitution, itself the result of acquired disease of bad unhygienic



living and environment, may manifest itself in the offspring under the various forms of idiocy, epilepsy, hysteria and other neurosis, a tendency to phthisis, or facility to be attacked by and to succumb from prevalent diseases, and in a bodily configuration indicative of these weakened "degenerate." constitutions, that the residual effects of infectious disorders and also of injuries often influence the offspring; in other words, that "degeneration can be" produced in the offspring by ancestral morbid influences, even of a microbic acquired or accidental nature.

It is a matter of common experience that the children of senile parents are often weak, unstable, precocious and unlike those generated in full adult life, and that though this is not so universal, the same is often seen in those of extremely youthful parents (one's experience in India where early marriage is the rule does not bear out this assertion, which is however very largely made).

It is also well known that peculiarities of bodily conformation, deformities and the like, are notoriously often handed down for many generations, while on the other hand they tend to gradually disappear when the family is "crossed" with others devoid of any heredity of the same, and *vice versa*.

We may therefore say that not only may ancestors marrying affected persons, or still more so the intermarriage of two with the same defect—this may be transmitted to the offspring—an indubitable fact as regards insanity—but that parents living unhealthy, vicious lives, encouraging unhygienic surroundings—or parents weakened, by disease, injury or senility can, and do, transmit to their offspring a lowered vitality, a tendency to weakness and disease, their children starting on a lowered plane of physique to themselves—these if they continue in the same habits, mode of living, and environment and uniting with similar beings of the other sex again transmitting the tendency to *their* children, who also start life on a still lower plane. The offspring in each generation being "degenerated" and continuing to become so in a progressive series, while these causal conditions continue.

One visible result of such a condition in all cases is the appearance of "stigmata" as evidences of degeneration already alluded to

In the infant where vitality is so affected certain organs or cells cease to follow the usual course of development, at certain stages producing either one or several of the "stigmatic" bodily charac-

teristics, or the cerebral or constitutional deficiencies resulting as the neurosis, or other affections enumerated. We may therefore reasonably say that these latter, the bodily peculiarities referred to, are evidences of "degeneration" in the individual, racial or otherwise, instances of "imperfect evolution dependent on an arrest of development." "Degeneration constituting a form of disintegration the reverse of integration" (E. S. Talbot).

One may here digress to point out that, though the congenital nature of the affection is evident sometimes in the case of the idiot, moral imbecile, and perhaps also of the paranoiac. As regards ordinary mental affections, it is much more probable that for these and Epilepsy just as for Phthisis it is the vicious "tendency" that is transmitted, the potentiality of the organism to suffer from them when assailed by any overpowering stress—or even it may be (such is our ignorance really of the pathology of insanity) of some micro-organism or other cause yet unknown.

Therefore, we may say that, as a result of the heredity direct or indirect of disease, injury, sunstroke, abuse of alcoholic or other intoxicants, bad living, unhealthy climatic and social environment, children are born with a vitiated degenerated constitution, more and more evident as these morbid influences have been repeated in former generations and only possible of diminution by the atavism to some more healthy predecessor. That as a result of this are born idiots, moral imbeciles, the congenitally deaf mute and blind; people with a tendency to insanity, epilepsy, hysteria, neuroticism, crime, one-sided genius, prostitution and to pauperism, to nervous disorders and other affections, one and all bearing bodily evidences of their "degeneration" in the "stigmata" which are common to all persons of these classes.

It is obvious also that as this condition continues, it eventually tends to extinction of the race by production of feeble individuals prone to disease, and finally of those incapable of procreating their species.

The ordinary physical neuroses are described in the text-books on Nervous Diseases; a description of insanity and its attendant disorders has been attempted in this volume; the questions of prostitution and pauperism cannot be here gone into, and it only remains to refer to those of "one-sided genius," the neurotic and the criminal, though of this latter it is only possible here to refer to the detection in them of the evidence of insanity:

A very interesting summary of the large amount of literature

on this subject is given by Eugene S. Talbot, "Degeneracy, its causes, signs and results." Scott Pattersby Co.

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## CHAPTER XXXVII.

### ONE-SIDED GENIUS.

THERE is a relation between moral Imbecility, ordinary Insanity, Epilepsy, Degeneration and Genius, or as some put it, strange as it may seem, Genius is really a neurosis, a congenital or (as it has been stated sometimes to have only made its appearance after an injury) occasionally an acquired mental abnormality. Repugnant as this statement may appear to many, a close examination of individual examples possessing it (Genius) and of the works of writers who like Lombroso and others have minutely investigated the subject, only too clearly prove the truth of the theory. Even after granting their utility, the magnitude of their achievements, everyone will own, that in general men of genius are lacking in tact, moderation, the commonsense of practical life, and often in the very commonplace, but essential faculty, for self-maintenance and in the conduct of ordinary everyday affairs; as is well known, it has been said that "everything is permitted to the man of genius," and it is notorious that such men have been in many instances, one might go so far as to say in the large majority, of loose morals, irregular life, absolutely wanting in altruistic feeling and even if not openly so, essentially inconsistent, preaching, writing grandiloquent sentiments of virtue and yet leaving those nearest, and who should be dearest to them, in want and misery.

Put briefly, the arguments are these. Many men of genius have been at some time in their life insane, and others epileptic, while a very large number, though not recognised as ever having been insane, can be proved to have suffered from delusions, hallucinations (*ex* Swedenborg), obsessions (Johnson), to have had attacks of abnormal "melancholy" (Goëthe), and many, very many, have been wanting in moral sense (Bacon). Also many have been born of families, members of whom have been insane, epileptic, alcoholic, eccentric and degenerate, while others were the progeny of parents of advanced age. Not only this, but a very large number shew the psychical and physical characteristics indicative of degeneration a moral apathy and lack of the moral sense (of all the peculiarities the most common in such people), a tendency to impulsiveness, to

"doubt," peculiar faculties of memory (seen also among certain imbeciles), exaggerated loquacity, or more rarely mutism, an excessive vanity, an inability to brook restraint or contradiction, and an egotism only equalled among insanes, a tendency to put a mystical interpretation to the simplest facts, and a fondness for symbolism such as is common in the neurotic and unstable, while many shew an extraordinary insensibility to pain, a dulling of the ordinary feeling essential to self-preservation, such as hunger, which can only be regarded as pathological; as is the sexual precocity so very common among them. Physically, many of them even relatively in larger numbers than among the insane exhibit the prominent misshapen ears, the deficiency of beard, the asymmetry of face and cranial peculiarities, with irregularity of the teeth, the smallness or disproportion of the body, the left-handedness, stammering, the proclivity to phthisis, the pallor of the face, the excessive fecundity, neutralized afterwards by abortion or complete sterility, with constant aggravation of the abnormalities in the children, all recognised as the stigmata of degeneration. While equally noteworthy as evidences of its pathological character are the recorded instances of men of genius only becoming such after an injury to head or spine.

We may define conduct as the active adjustment of self to circumstances in the environment individual and social—the physical features of the environment those connected with self-preservation, of that of the species and of the social relations and those connected with the religious or if it is preferred to term them the moral observances of conduct, undoubtedly the highest-most far-reaching of all. On the other hand, a man is said to be possessed of genius who exhibits "intellectual endowment of the highest kind especially of invention or original combinations," or as is sometimes said who has a faculty "enabling him to reach his ends by a sort of intuitive process." Talent, it may be added, being a little lower grade, in that it means a great facility in one particular capacity or line of conduct, *i.e.*, it is less original and inventive.

Now, however much we may admire the possessor of one faculty of great pre-eminence, and a genius is rarely so in more than one direction, this should not blind us to the fact that unless its possessor has a capacity in other respects, equal to the average, that is to say, that he is able to regulate his conduct as above enumerated in the manner recognised by the majority of the world as normal and proper—that he is not only abnormal, but wanting in

the ordinary proportion and capacity of human beings. There was shewn me once in a well-known Idiot Asylum in England, a man of 40, obviously weak-minded, incapable of volition or of self-protection, or of self-maintenance, who yet could answer almost any mathematical question, especially in relation to date or time, with a rapidity and accuracy not to be equalled by any of those examining him. One could not but admire such a capacity, but no thinking person could fail to perceive that it was an abnormal faculty in an abnormal being. Now, this is exactly the position of a man of genius, perhaps in a less degree.

There have been a few, a very few, like Cæsar, Spinoza, Socrates (?) who with the very highest intellectual gifts combined a rigid integrity, a capacity for well-ordered regular living, and for the maintenance of themselves and of those dependant on them, but a careful examination of the life history of most men of genius will convince any one that such instances can be counted on the fingers of one hand, and that the overwhelming majority shew some (usually several) of the peculiarities above enumerated, that they are not men with a sound mind in a sound body, but would appear to have perhaps one intellectual or artistic faculty developed at the expense of everything else, or as it may be suggested this only appearing so by the deficient development of those subordinated—and what is very striking is the large proportion in which such people show a deficiency, in that which is the highest of all intellectual acquirements, the moral sense—for nearly all shew a complete “moral apathy,” a deficiency, or incapacity to appreciate the ordinary rules of moral and altruistic feeling, or to conduct themselves as the rest of the world regard as right and proper, a particular failing so frequent and well marked as to rank them very closely with moral imbeciles.

Not only is this so, but a regular gradation on examining the history of such people, can be traced between the men of genius whose intellectual pre-eminence is unquestioned with others to those whose efforts, literary or artistic, or what not, shew many of the characteristics usually found in the production of insane persons. From these again to the individuals described as “mattoids” (Lombroso), the “cranks,” men who write enormous tomes to shew how to square the circle, how to produce perpetual motion, etc., etc., the examples are endless; the works always shewing endless self-evident contradiction and absurdities, or being reasoned on false premises, and in many other ways shewing that

they are the production of what are practically insane persons, who only disclose their insanity in their writing. Curiously enough, these persons shew a wonderful similarity in various traits, though, unlike insanes, they recognise one another, and aid one another; they have a curious capacity for abstinence and even semi-starvation; they exhibit an unbounded vanity as to their own achievements and discuss them with a calm conviction only equalled by some paranoiacs. These instances again fade into those of the decadent poets, the "symbolards," the religious lunatics and the religious fanatics who have been at some time notoriously insane, and these latter again into the actually insane, who exhibit, as do a very few of them, a certain capacity (as a general rule of an inferior order) for art or literary production.

There is no sound dividing line between any of these divisions; history will present examples of every degree of gradation between them, and their lives joined to their family histories, their bodily configuration and characteristics, physical and mental, so frequently seen, clearly shews that those who regard their capacities as only evidence of another form of neurosis or psychosis only differing in degree from that affecting their near relations—that these observers have considerable grounds on which to establish their opinions.

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## CHAPTER XXXVIII.

### THE NEUROTIC TYPE.

THERE are a certain number of persons most easily recognised in young adult life, commonly spoken of as "neurotic," who are really examples of a result of degeneration from hereditary influences. (One of the most marked cases coming under my notice was a European, the daughter of a neurotic mother, married to a shy, timid man, whose parents had married when sixteen. The mother herself being generated when her father was over 80 and her mother 20. She had a markedly neurotic sister subject to ungovernable (*sic*) fits of passion, and though twice married, childless; her other sister was an excessive talker, she herself typically neurotic, suffering from erythromyalgia and full of fads for which she utterly neglected her numerous family.) These people are of great interest—there is always a liability in them to insanity from any unusual stress—especially insanity of the exhaustion psychosis type. They are a

source of great trouble to their relations and friends from their behaviour and their liability to ill health. Being usually superficially bright, vivacious and of good appearance, they marry readily and so tend to perpetuate (unless united to one of the opposite sex of much superior physique) their own infirmities, and they are surprisingly long-lived, though on the other hand very prone to the incidence of tubercular disease. These people who are of either sex present certain physical and psychical peculiarities, trifling when regarded singly, but very significant when united as they usually are in these young people in their entirety.

(1) The patients are usually above middle height, very rarely they are of extremely small stature. They have, what is usually popularly spoken of, as a delicate physique.

(2) They are almost invariably thin, especially evident in the face with a peculiarly delicate skin and a "delicate," "fine" complexion (as opposed to a fresh one), often with a liability to vaso-motor instability shewn in pallor and blushing that procures them a reputation for a "beautiful" complexion.

(3) The hair is very fine, silky, not abundant, and soon tends to fall out; it is never thick and strong.

(4) There is usually myopia, often of a very high degree in one or both eyes.

(5) The teeth decay easily and give much trouble.

(6) These people are peculiarly susceptible to heat—are always declaring that they require more air, are intensely prostrated by any great rise of temperature—and are on the other hand markedly impervious to cold; on this account they are often a source of great annoyance to others not equally endued, for they insist on having windows and doors open in all weathers and object to any methods of warming the apartment, etc.

They have from early life a tendency to suffer from most distressing headaches, often vertical—or backache; menstruation is frequently very profuse. They have usually very little desire for food or at best a most capricious appetite, taking strange fancies and dislikes to particular articles of diet, etc., and it is at all times difficult to make them take plain and sufficient nourishment.\*

In childhood they early shew neurotic excitability, the slightest perturbation or excitement is followed by sleeplessness, restless-

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\* In such persons what is commonly spoken of as "tickling" produces no irritation.

ness or even delirium or hallucinations; they fall a victim to somnambulism, night terrors, to morbid fears, imperative ideas, to convulsions with any rise of bodily temperature and delirium when this is maintained; they have an emotional irritable disposition with periods of exaltation and depression, are vain and egotistic, a condition increasing towards puberty, when they shew a tendency to vehement dislikes, or to form intense fervid attachments with those of their own sex, attachments however liable to a sudden termination and often changing to bitter dislike.

In young adult life the personality is very striking, especially in the typical female, generally "delicate," of thin physique, fairly tall stature, frequently with a reputation for ability, vivaciousness and energy, though equally well known in her own home for moods and fits of depression and "temper," with thin face, delicate skin, beautifully coloured complexion, thin silky hair, myopic, subject to distressing headaches, backaches and irregular or abnormal menstruation, a capricious scanty appetite, an utter incapacity for long and quiet sleep. Such young persons are most restless, "energetic" and changeable, to content them, if in a good station of life (and they are not common or noticed in others); their day must be a constant succession of rushing round the garden, hurriedly writing letters, riding their pony, playing at tennis, badminton or croquet—always late for everything, dreading nothing so much as being left to their own resources for half an hour—constantly talking and talking rapidly, breathlessly, unable to take due part in a conversation by occasionally quietly listening and reflecting, so much so that one may be assured that when you see a young female sitting quietly on a chair, placidly waiting or sewing or listening with patience to the lengthy conversation of another—that young person will never be a "neurotic." Such a one is peculiarly restless; if her activity is otherwise impeded, she must tap with her foot, move her fingers, or arms, her head, face or lips; muscular inaction is to her absolutely painful. If one attends to her conversation, it will soon be seen that she is inaccurate in her description, her defect of controlling power (which is perhaps the essential factor) not permitting her to either pay sufficient attention to her own statements, to weigh the effect of her words or to have noticed carefully enough when seeing or hearing the facts she is relating.

Such a one is peculiarly devoid of tact, implying thought before speaking, the judging of words and their effects, some



self-control and a use of experience of which such a person is quite incapable. Indeed, all her acts shew their deficiency of will power and control of concentrated attention, or of the desire and emotions uppermost for the moment.

Such a one is vain and egotistic ; even though her training may have forced her to a certain amount of concealment of this; still she has an intense love of admiration, which perhaps accounts for the self-consciousness that is such a prominent feature, as is almost equally so the love of novelty. The emotions are more on the surface than in quieter, more stolid people; that is to say, that such a one is easily excited, and with equal facility raised into the clouds with happiness, or sunk into the depths of despair a few moments later, and is hence easily led into imprudent acts that she bitterly regrets afterwards ; put into other language, there is defect of control of the emotions, which are in excess and easily excitable, and there is a hypersensibility to subjective and objective impressions.

With all this there is great capacity for affection and for what appears superficially to be altruism—carried away by their emotions and defective judgment, they will give away anything, even themselves, for others, and hence the way in which this class of unfortunates supply the instances of hasty, imprudent marriages—weak mothers—the pale hectic inmate of the convent—the breathless curate worshipping, church fanatic, or exponent of the latest fad and enthusiasm—it would seem cruel to say that this tendency was aided by their love of appearing interesting, though this undoubtedly is a factor that aids their emotions in their all-powerful sway.

Though such people may shew superficial ability, or some special aptitude, as for music, etc., it is doubtful, more than doubtful, whether they could ever attain prominence in any art or accomplishment, which requires for its acquisition long continued attention and patient industry.

The same defective self-control, the inability to weigh their words, to act with sufficient foresight, the inability to prevent the immediate gratification of any impulse, without reflection on its after effects, to avert by a little personal self-denial, patience and foresight, subsequent injury and loss to themselves, continues throughout life. Many of these people marry and have no children or perhaps even as frequently they have a large family—children when they arrive ; to seek immediate gratification are neglected or spoilt, and their future ruined for the want of a little

sustained exertion and continued self-denial—time that should be spent in training them is wasted in “amusement,” in constant flying from one to the other latest fad and craze, and the offspring are ultimately allowed to run wild, or to grow up with a deficiency in training and education, that adds its mighty effect to the morbid heredity given them at birth by their unfortunate parent.

Many of these patients, if women, develop after marriage wild theories of sexual relation, leading to great unhappiness, based originally on a defect of sexual desire that is characteristic of so many of them.

This neurosis, though not in itself insanity, is the fertile soil in which develops neurasthenia, phthisis and mental disease as a result of any shock, grief, or prolonged worry, and particularly of any affection causing rapid exhaustion. Many take on in similar condition alcoholic habits, and if such a one marries another of tubercular tendency, the children born of such a union almost certainly becomes at some time or another insane.

Though this type is common enough among Europeans in India, where their inability to support the heat is a very marked feature, it is rare among natives of the country, but then its detection requires a closer knowledge of the sufferers from it, than is usually possible to be obtained between Europeans and natives under present circumstances.

It is in no way to be confounded with the congenital neurasthenia described by Defendorf, *Clinical Psychology*, p. 378; indeed, it is in many ways very opposed to that condition, which perhaps more nearly corresponds with what we speak of as the “born tired,” the pessimist and the valetudinarian.

In itself this marked tendency is only another example of degeneration. In congenital neurasthenia there is an ever-present perverted tone of feeling, and an abnormal susceptibility to fatigue. Such people tire very quickly, demand and need frequent rest, and are thus incapacitated from steady application, not on account of defective will power, but because of the resulting headaches, exhaustion, insomnia, etc. Still, it must be owned that they are very distractible, they are unable to concentrate their attention so as to prevent this being attracted by any and every trifling incident in the environment.

But at the same time they are peculiarly inclined to be hypochondriacal, to make much of every trifling ailment; they are always pessimists, easily discouraged, always looking at the worst

side of anything, brooding over past events, and apprehensive of the future, and are always wanting in courage and self-reliance, frightened at the thought of any new undertaking, while deriving no pleasure from their occupation. These are the people whose conscience is always of a most exacting nature, who are very precise and punctual, who have a morbidly vivid apprehension of death and the "hereafter." Such are nearly always quiet, shy, dull, avoiding society, not mixing with their fellows but keeping aloof and to themselves.

Some form varieties of that class of people so well known who are always looking out for insults, fancying themselves despised, neglected, always hypersensitive and "difficult."

Though the disposition to the disease is congenital, it does not appear markedly evident until about puberty, when, accentuated by the cares of life, it remains permanently or for at least many years. Treatment is of course useless, and the only hope of improvement or amelioration is for the sufferer to find some congenial employment, not too exacting, in which he may succeed well, and which interests him. For, as before noted, the condition is much heightened by worry, anxiety and disappointment, in which case a mild form of melancholia is very apt to supervene.

## CHAPTER XXXIX.

### CRIMINALS (*in general*).

As before said, there is a strong connection between insanity, degeneration and criminality. If we analyze the various persons who have been convicted of crime, it will be found that they can be arranged in several classes, those being most usually described and as every one acquainted with the subject will agree, most correctly, though the names given to each are of little moment, as—

- (1). Political prisoners.—These in countries under British Rule are so small in number that they can practically be omitted. They are not criminals in any true sense of the word.
- (2.) Criminal Insanes.—These it is the object of this work to more particularly describe.
- (2a.)—Instinctive born or Congenital criminals.—This is really only a variety of the above and to be considered with

them. They are practically synonymous with what is usually described as moral imbeciles.

- (3) **Criminals by Passion.**—In this class are included first offenders, often of previous good character and history, who commit some crime usually against the person, under strong emotion ; the classical example is the man who kills the seducer of his daughter caught in the act, etc. It is obvious that only the history of each individual case, and that of the person committing the deed, can justify a person being included in this class and that it is matter of opinion. I would, however, point out that many prisoners in this country, such as those concerned in unpremeditated deeds of violence in quarrels about water, and deeds of violence of the same character committed by men on the frontier would seem to come under this category: these men are often indeed usually of low intellectual level, and therefore with less emotional control and in the latter particularly they have often for generations been in the habit of settling quarrels in this manner: they are nearly always, while in jail, of exemplary character, and an intimate knowledge of them in prison, such as is obtained by any Superintendent, convinces one that they are not criminals in the true sense of the word at all.
- (4) **Occasional Criminals.**—The chief features of these are that they are men of weak character, and that under trying circumstances that men of stronger moral fibre would resist, they fall into temptation, give way and commit a crime, usually of the nature of theft, etc., the acts usually bearing no evidence of premeditation. Such, however, from the moral contamination of a prison, etc., usually become later members of the next class; the examples usually given are of persons in great want or poverty, who seeing an opportunity of taking something to relieve their pressing necessity steal it. They are always obviously first offenders.
- (5) **Criminals by habit.**—These are often a growth from the preceding class, people of weak nature, who having once given way to crime, even if this is undetected, continue and usually increase the magnitude of their

offences each time. Many of the habitual criminals, specially of the lower castes, are of this type in India.

- (6) The Professional Criminal.—This is the man who deliberately chooses vice as a career ; he is usually of good intellect and ability, is generally irreclaimable, and inherently vicious ; their crimes, even first offences, having no extenuating circumstances whatever.

A very little reflection on the case of any convicted person will convince an observer that every criminal belongs to one or other of these classes.

An immense amount of labour has been expended by a crowd of investigators as to the physical, bodily characteristics of criminals, their heredity, the several "cosmic" and morbid factors relating to them, and a huge amount of material has been collected in consequence, which has led to a certain amount of controversy and several diverse theories and interpretations.

The subject has, however, been much obscured by the simple fact, that as it seems all of these researches, certainly those appertaining to the facial, bodily, physical characteristics, have been taken from criminals as a whole, and the results for each particular class have not been separated. This explains the fact that the general results of the investigation has been to find that criminals present many of the abnormalities, the stigmata, etc., usually found in insanes and epileptics, and it is this fact that has led very often to sweeping generalisation and imperfect theories ; those results found can be easily understood when we remember that a large proportion of criminals are, as every one allows, insanes, moral imbeciles and weak individuals of degenerate parents, and low intellectual development, and, therefore, naturally present these peculiarities. What would be more to the purpose, and what has not yet been done, would be an equally thorough examination into the characteristics presented by the Professional Criminals as a class, the Criminal by habit as a class, and in the same way of the Occasional Criminals, and the authors of crime by passion. It would then be possible to form a reasonable conclusion as to which innate bodily peculiarities helped to form a factor in the production of crime.

Bearing in mind these remarks, *i.e.*, always remembering that these are taken from criminals as a whole, it may be of interest to summarize the general results found by most observers.

Though the average size of the heads of criminals is partially the same as that of the ordinary population, there is a larger proportion of small and large size, *i.e.*, medium sized ones are deficient. It is believed that the average size of the heads of thieves is small; that of murderers large. In many the cephalic indices are an exaggeration of those of the race to which they belong; many present heads of a curious conical sugar-loaf type, and in many others these are low, flat-roofed.

There is a preponderance of larger facial development, with smaller anterior cranial, than among the ordinary population, as there is of men with a large orbital capacity, and an exaggeration of the supra-orbital arches and frontal sinuses. Receding foreheads are common, as are prominent superciliary ridges, and large frontal bones and orbits and large lower jaws.

Many present cranial asymmetry, and many more shew the union of many defects in one person, an extraordinary relative preponderance of evidences of atavism and pathological characters; it is said that twice as many prisoners present stigmata of degeneration as do normal persons, a fact obviously capable of several interpretations. When examined after death, wormian bones, peculiarities of arrangement of the cranial bones, an average deficiency of weight of the cranial contents, and various peculiarities in arrangement of the brain convolutions are very commonly discovered.

As regards the face, a prognathous face is very common; in others, a peculiarly receding chin, especially, it is said, in criminals of weak pliable natures, a prominence of the teeth, of those of the lower jaw, the reverse of the usual position as regards those of the upper, a deficiency of wisdom teeth, and an undue length of canines are common anomalies, as are peculiarities in the shape of the palate.

The ears project much, are large and outstanding and often present peculiarities such as the Darwinian tubercle doubling of the posterior branch of the fork of the antihelix, a conical tragus, etc., and certain persons would assert that these aural peculiarities are usually combined with sexual abnormalities. Taken as a whole, ear anomalies of criminals, as of insanes, are greater in number and of greater gravity than those of the ordinary population. Besides these a Bichromate iris is common as is an intense pallor of the skin, and an earlier and greater appearance of

wrinkles of the face, especially of the lower portion, contrasting with an absence of those of the forehead.

In men the beard is frequently very scanty (except it is said in sexual offenders), but it is late in turning grey, and baldness is very rare, though commonly enough the majority of female criminals have luxuriant hair which turns grey early, and they have frequently hair on the face and around the anus, a decided abnormality in women. This, however, is only another example of the fact that female criminals approach to a masculine type of body; they are often celibate; they become criminal later in life, *i.e.*, after child-bearing, which is the strongest preventative in them of true criminality. Women, it may be added, are far less criminal than men, the only exception being as regards parricide, of which crime exactly as many women are guilty as men.

Taken as a whole, criminals of either sex resemble insanes in rarely exhibiting beauty, and in the large majority showing some peculiarity of appearance, so that perhaps for that reason prisoners present a certain uniformity on the average of general appearance; added to this, many have also a peculiarly cringing timid look, an expression of mobility and cunning, contrasting with a peculiarly fixed look of the eyes that is said to be characteristic. Less obvious anomalies in criminals are said to be a tendency to left-handedness in twice the proportion found in normal people, and a marked number of males who have female characteristics or rather resemblances in the shape of large nipples and areolæ. Among the total number there is a deficiency of medium statured individuals, with the presence in the large majority of an undue length of arms, and a relatively large number also show deformities of the chest, the genitals, and the jaw. And what is very significant almost, all criminals are markedly deficient in physical sensibility.

Taken as a whole, it is obvious that, to put it briefly, a large number of criminals shew the stigmata, the physical peculiarities, common to many insanes (it is asserted that they do so in even greater proportion), and to epileptics, these same being usually accepted as evidences of physical degeneration.

Whatever views may be deduced from these undoubted facts, or whichever may be taken of the conclusion of various investigators into the subject, its interest and importance is obvious, though this is not the place to discuss it. It is a study which will well repay the trouble expended, and in this particular there is perhaps no more able and interesting work in English than the

skilful summary of the subject by Havelock Ellis on the "Criminal" from which most of the above notes are taken.

Quite as important, however, in the production of a criminal is the influence of heredity, either direct in transmitting a tendency to crime, or as shewing how large a proportion of these men have insane, epileptic or alcoholic parents, how many of them are born of aged and immature parents, the latter factor being, as is well known, frequent in the heredity of idiots, and the weak-minded, and directly opposed to that of the average of normal persons. In the same connection is also the well-recognised fact, that a pure criminal is one of a family of such, all his relations being so too. In all these relations, however, the social influences of home training and example must always be remembered; in the case of criminals born of alcoholic parents such an influence must be particularly potent, although, on the other hand, it is well recognised that marked alcoholism is a sign of mental instability. In this connection it may be also noted that while for the same reason high evolution tends to lessen the number of the offspring criminals, obviously a result of devolution and degeneration often belong to large families. Looking at the subject from another aspect, perhaps the most fundamental characteristic of a criminal is, his total lack of moral sensibility; remorse for having committed a crime is with such men absolutely unknown; indeed, where it is seen, the individual is certainly either a "criminal by passion" or in no sense a criminal at all. The two essential factors for crime seem to be moral insensibility and perversity, combined with improvidence and lack of foresight, a possession of which would in many, from a merely commonsense point of view, prevent their consummation. In these men stupidity and cunning are curiously combined (though this latter remark does not apply to those who follow fraud as a fine art). The instinctive criminal, on the other hand (the moral imbecile), is marked, by a continuance of many of the same peculiarities (cruelty for example), as are found in most healthy children; like them, they rarely dream, they are deficient in attention, in power of application, and they shew the restlessness characteristic of children, or of those beings with deficient intellect, many especially when young, and this is particularly obvious in reformatory schools, shew a great want of memory capacity, all their astuteness depending on an instinctive power, not on reasoning. A criminal, in fact, being essentially weak, mobile, excessively emotional and



lacking in inhibition, and in so much a departure from the normal standard of human beings, a degenerate being.

In regard to their mental peculiarities, criminals are curiously vain and egotistic—vain even of their infamy; also they are peculiarly unstable, emotionally incapable of sustained exertion and always idle, crime of course in the large majority being essentially actuated by a desire to avoid work.

They exhibit a craving for excitement and some stimulus, alcohol, gambling, sexual excitement, perverted sexual gratification, though this latter remark needs to be qualified for natives of this country where such is habitual among the ordinary population. Many of these shew in confinement emotional storms, outburst of frantic excitement, especially among the women, fits of violent passion, often coincident in females with the monthly periods.

Many prisoners describe irresistible instinctive impulses as the cause of their criminal acts, and perhaps in relation to them are the curiously contradictory tendencies some of them shew for love of animals, children—or in their power of appreciating sympathy, or in their superstition, one cannot call it religion, which is very frequently noticed; some use mascots, while others are rigid in their observances of some religious formulæ, even so especially when about to commit a crime; this is obviously only a reversion to the old disassociation of religious observances and morality or rather to the lack of belief that the two are necessarily associated. Religion in former ages was adherence to ceremonial observances in which morality, *i.e.*, rules of conduct, had very little connection. This is very clearly seen in Indian jails, where it is rare for a Mahomedan prisoner to be without his Koran, and where even the man convicted of most dastardly crimes would never think of soiling or sitting on it or even offering it disrespect to the extent of laying it upon the ground; it must always be hung up. I have myself seen 500 prisoners guilty of every description of crime brought together to till an hitherto uncultivated patch of land, willingly and unanimously before breaking the first sod—they were a mixture of Sikhs, Hindoos and Mahomedans—call each on their God to assist them—at the request of the head jailor, himself, as I had full knowledge, an acceptor of bribes and an able but absolutely unscrupulous man.

Lastly, criminals evince peculiar and distinctive habits. Tat-

tooting is very common among them (in some countries those marked in this way being 15%), chiefly a result of idleness (it is perhaps scarcely necessary to remark that criminals, prostitutes, vagabonds, like insanes, are essentially unproductive) and vanity or for some erotic reason. It is, however, a very rare habit in women, and is practically (with the exception of some marks made on the followers at certain shrines) unknown in India though common enough in Burma. Then, there is the tendency to the use of a particular slang in language, all customs tending to produce the feeling of a common race and interest, and in themselves evidence of a community of feeling, just as is their total absence of remorse, and the theories many such men hold that their occupation is a legitimate one, and a perfectly justifiable reprisal on the usurpation of those of the wealthy or governing classes which shews another instance of the essentially antisocial bearing, the abnormal condition and obviously degenerate level of the individuals forming this particular class.\*

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## CHAPTER XL.

### CRIME IN INSANES.

It, therefore, appears that criminals present a far larger proportion of anatomical abnormalities than the ordinary European population, and as this is precisely the characteristic anatomy of the lower races; we may then very reasonably conclude that a criminal is not a normal being, that crime is atavistic, a tendency to a reversion to a savage, antisocial type; that criminality is a failure to live up to the standard recognised as necessary in the present community, and, therefore, that the majority of persons committing crimes are predisposed to do so by the heredity of physical configuration, aided often by their training and environment, and on that account less blameworthy than is usually supposed.

But whatever views we may have on these points, and on the treatment proper, and most suitable for dealing with them, this is

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\* These remarks apply to the average of criminals, they do not affect the fact that a few criminals may have been of high intelligence, but they then approach the type of men of genius, who are also in the large majority nearly allied to those beings born lacking in moral sense, the condition itself being undoubtedly a neurosis.

not the place to discuss them, and everyone will allow that the safety, comfort and well-being of the general community demand that the normal population should be protected from them and from their acts, though whether the present means for doing so is suitable is not the question in point here. The method of doing so by punishment is laid down by the law, to which we are also amenable, and the only persons that are exempted from the punishments of their offences are those who can be proved to have committed them when insane.

It is, however, well known that many acts now regarded as crimes were among savages and earlier races not looked upon as such ; parricide, infanticide, and some varieties of murder, such as are involved in human sacrifice, and what are now looked upon as vicious acts, were and indeed are still in many countries regarded as perfectly natural and reasonable, indeed often praiseworthy ; to this day incest with every female relation except the mother is common in Bhutan, and infanticide in China. The same can be said of insanity ; a person rightly regarded as insane now would have been often so in any country and century ; but on the other hand, there are many instances in which, as in the present day, an insane person was regarded as inspired or bewitched, a very common belief in this country and across the border. Still, a distinction always has been made between the acts of such a one and those of another who is regarded as effecting them voluntarily, and by his own power. In the present day this is absolute, *i.e.*, one regarded as a criminal is punished by law and one looked on as insane is segregated under medical treatment, and it is precisely on this point that a medical opinion is so frequently asked for, *i.e.*, as to proving the person committing a deed to have been insane. It must be remembered that as doctors, we are not asked our opinion of the accused's responsibility (or we should not be, for that involves a much wider question), we have simply to declare whether in our opinion the act was or was not that of an insane ; not only that but as is reasonable, for we have no right to expect people to blindly follow our opinion, we shall be usually asked for the reason on which we form our judgment, and it is for the assistance of those medical men, and others called in evidence on these points, that I have ventured to summarize the various forms of insanity, in which the most common crimes are committed, and have also added an epitome of all the cases of criminal

insanes that have occurred in the Punjab since 1900, all of whom have been under my observation during their detention.\*

The obviously insane men give very little trouble in distinction, but it is not so with those in whom this is not apparent to untrained persons, and many of them present great difficulties, not however insurmountable.

The first consideration is obviously of the act itself. What distinguishes an insane act from a purely vicious one? Now, we may define a "fault" as essentially an omission to do something, a neglect of duty or propriety, and a sin as a transgression, of what is regarded as a Divine law, and an instance of moral depravity.

While we usually speak of an act as imprudent, when there is a possibility of the future disadvantage accruing from it being greater than any probable present advantage, just as we describe one as prudent when effected with a careful consideration of the future results. So we may usually describe virtue as the foregoing of immediate gratification, for the sake of greater future benefit; and vice as the instant indulgence of desire at the cost of future disadvantage (Clifford Allbutt's *System of Medicine*, Vol. VIII). If this disadvantage only reacts on the doer, an act of the latter character can be regarded as purely vicious, but if it entails a future disadvantage on others, if one's own advantage is sought by means of injury to others, it then becomes wrong-doing, the "intentional injury of others for the gratification of oneself," and if this wrong-doing is against the law or rather is punishable, it is regarded as a crime, and then comes under legal notice and is liable to entail punishment.

On the other hand, an act is only obviously insane when the immediate benefit procured is absurdly out of all proportion to the subsequent disadvantage and injury it obviously entails on the person committing it; examples of such, however, are rare, and the majority of acts of insanes are not of this character. Looking at it from another point of view, it is quite clear that the power of "foregoing immediate indulgence for the sake of greater good" is

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\* One may here digress to point out that criminal insanes in India are divided into—Class I, insane and unable to plead at the time of trial; Class II, acquitted as though they have committed the crime they were insane at that time; Class III, convicted criminals who have become insane while undergoing their sentence.

When our opinion therefore is asked in relation to Classes I and III, it is simply a question of the ordinary diagnosis of insanity. What we are now about to discuss, is whether a certain act of which a prisoner is accused was committed by him while insane—he or she may be quite sane when we examine them.

in no way in any direct relation to the power of the intellect ; we see it highly developed in many stupid people, so much so, that this particular connection is almost proverbial, and we see it markedly absent in many men of high ability. But a true criminal is directly antagonistic to his social surroundings and of course is supposed to be conscious of the nature of his acts, and what is of more importance to be able to control them, whereas an insane, though he may be also antagonistic, is either not able to control himself, or is actuated by some insane idea, for which he is not responsible, and in some cases (not by any means all) is unable to recognise the nature and consequences of his acts, or of right and wrong and to act accordingly.

It used to be generally essential to shew, that the individual in whose behalf a plea of insanity was set up, could be classed among one of the 4 great divisions either as (1) suffering from *Dementia naturalis*, the "fool natural," whose mind had failed to develop or (2) from *Dementia adventitia* which included persons, formerly sane, who had lost their reason, or (3) the lunatic, the insane possessing lucid intervals, or (4) those who by their own act, such as drunkenness, had temporarily lost their senses, the last not necessarily having any privileges of insanity—and to shew his incapacity by proving the existence of delusion, and that he was incapable of distinguishing between right and wrong, and knowing the consequences of what he did at the time of the act in question. These distinctions, however, do not embrace all the present known varieties of insanity.

To the lay mind the essential features of madness are those broad, salient peculiarities in which the patients differ from ordinary persons, the changes in manner, habits and disposition, from those customary before—the extravagant delusions as to environment and personal identity, the maniacal fury, the restlessness and incessant chatter, or the melancholic's depression and silence, or the demented's fatuous expression and loss of reasoning and memory.

These features are certainly all characteristic of insanity, though they are not found in some particular types of it, and for this reason it is extremely difficult to embrace all the varieties of mental disease in one comprehensive definition, though the attempts to do so have been very many.

A very old one is that of Locke, who in the simple language of his time states, that "mad men put wrong ideas together and so

make wrong propositions, but argue and reason right from them, but idiots make very few or no propositions, and reason scarce at all," Chapter XI, para. 13, or again when he declares that "madness is opposition to reason," Chapter 33, para. 4. Such a ruling would omit a large number of cases of mental disease. Cullen defines insanity as a prolonged departure without adequate cause from the state of feeling and mode of thinking usual to persons in health. More correctly, perhaps, Bucknell calls it a disease of the brain, affecting the integrity of the mind, whether marked by intellectual or emotional disorder, this not being the mere symptom or result of fever or poison. It is the latter exception which to many would vitiate the definition. A person in the delirium of fever, or as a result of *Cannabis Indica*, is certainly insane and unable to control himself—whether he is responsible in the latter case is a matter of opinion.

Maudsley, p. 1, *Pathology of Mind*, describes it as such "derangement of the leading functions of thought, feeling and will together or separately as disables the person from thinking the thoughts, feeling the feelings and doing the duties of the social body in, for and by which he lives."

A complete "perversion of the ego," "sufficient power of self-control should be the essence and legal test of insanity if we had any means of estimating it correctly," for undoubtedly a loss of self-control, a state of defective inhibitory power is the essential feature in all insanity; whether this is recognised in the surrender of the ego to the unreasonable sense of mental depression, the hypochondriacal sensations, the apathy or resistance to the environment, or in the submission to the overpowering sense of dread of any of the varieties of melancholia, or whether we see the same in the general exaltation, exhilaration or excitement in cases of mania, the passions arising from disease so characteristic of all its varieties, or equally so in the calm conviction, without an effort of correction by judgment, or reflection, that is such a salient feature of delusional insanity, or in that last stage of all, the failure in varying stages of completeness of volitional, emotional and intellectual power, with loss of reasoning and memory that marks the dement or the idiot.

Perfect self-control, under all circumstances, is of course only an ideal condition, though the law assumes that all have it, and only make exception in cases of children and insanes.

Children, it must be remembered, begin life with no inhibitory

power whatever, and only develop a power of controlling their desires, emotions and passions, as they progress in age as a result of training, and judgment and reflection, aided by the predispositions, the potentialities, call it what you will, which the special heredity of each supplied them with at birth.

Some, however, those whose ancestors have been criminals, drunkards and insanes, never develop completely or at all, and they are characterised by a marked intensity of desire, and marked weakness of control, usually it will be found associated with emotional excess or instability. Such form the origin of some of these debatable cases which comprise a certain, and in my opinion, not a small number of patients, who, to observation, seem to have perfect retention of their intellect and reasoning, who seem to retain the appearances and habits of sane people, but in whom there is either an insane "impulse" to commit some criminal or unsocial act, or an incapacity to control furious fits of rage to which they are frequently liable, or, as in others, who seem totally deficient in any moral self-control, and who are in fact morally, and only morally, insane; people who more nearly approach the criminal than the lunatic, who seem to inhabit a border land between crime and insanity, and whose consideration for a medical man called upon to give an opinion as to their mental condition is one of extreme difficulty and importance.

It must be remembered that practically every insane person is a potential criminal, at the very least he is egotistic, selfish and without regard for others, usually being incapable of any such consideration, and it is in this way that the majority of insanes are perpetually committing acts which would be criminal, immoral, indecent or improper in normal people.

The melancholic pays no attention to his dress or appearance, is unclean, often indescribably filthy, as is also the maniac, who is frequently, in addition, grossly indecent and given to assaulting his attendants and companions, and often is wildly destructive and harmful, even taking life in his blind fury or as a result of a delusion. The dement is unclean without any sense of proper behaviour or decency, and many idiots are on a level in this respect of an infant, while the paranoiac with a delusion of persecution will murder the person he supposes to be tormenting him. There are, of course, some insanes who do not have as an accompaniment of their acts, these marked intellectual aberrations, that mark and excuse the others; with them, their loss of power of inhibi-

tion is the chief and only symptom ; they may behave and reason, speak and judge, apparently perfectly correctly, yet they will, if affected with impulsive insanity, be liable to do some criminal act, of theft, arson, animalism or even murder, in obedience to a blind impulse they declare themselves powerless to restrain, or if belonging to the class of moral insanes, they may be vicious, cruel, wickedly animal and ungovernable, while intellectually bright, even brilliant and quite free from delusions.

Whatever may have been the type of insanity, the crimes committed by such people frequently, indeed usually, shew certain peculiarities which help to distinguish them from those of sane people. We may take, for instance, the list of those for which all prisoners in the Punjab were confined during, say, 1905—they do not vary materially from year to year—and look on these as typical of the relative frequency of various kinds of crime among the ordinary prison population, and we may contrast with these (the two tables are given on page 255) the list of crimes committed by all the “criminal lunatics” in the same prisons in the Punjab who have been detained from the years 1900 to the end of 1906—all of whom have been confined in this asylum and under my supervision. The difference in the type of crimes is very obvious and striking.

(1) It will be at once clear, that crimes of violence (most usually murder which alone makes up 54·5 per cent. of all those committed) are the most frequent form of misdeed committed by insanes, while theft is relatively rare, that and especially fraud being the metier of the sane vicious criminal.

(2) Then, again, it will be noticed that the crimes of insanes are of an unnatural character. The table on page 255 shews the enormous preponderance of near often beloved relatives, wives and little children killed, often too, in a violent unnecessary brutal manner, and a perusal of the histories of the cases given in the appendix, brings this out even more clearly ; for instance, what sane man in this country would come out in the early morning and brutally murder his two little children and attempt to do so to the third for no obvious reason or benefit.

(3) Then too it will be found that the act was usually quite unpremeditated, and generally seemed to have been effected on the spur of the moment as though in an impulsive manner. Almost always the crime was motiveless, very, very rarely in revenge, and even then for some childish trivial offence. Often it seems as



though the sight of some weapon, etc., at hand had instigated the deed, and in this connection it may be pointed out that deliberate poisoning is never the act of an insane. (The exceptions to this latter statement as to poisoning are recorded.)

(4) The crime is almost invariably unaided ; it is a well-known fact that insanes never combine (while insane) and it is one of the rarest things to see two lunatics talking even together (one may see them abusing one another or fighting and disputing). Every lunatic keeps to himself, and very grave doubts should be entertained as to the insanity of any man committing a crime with assistance (the only exception to this being those rare cases in which a weak-minded imbecile becomes the dupe and tool of others and helps them to commit some offence, usually theft, etc.).

(5) Also the act usually has some curious incidents connected with it ; the murderer will stay by the body of his victim or he will do some other foolish and peculiar thing.

(6) Nearly always there is no attempt at concealment or escape. One woman sat by the body of the child she had murdered all night ; another was found three days after with the decomposed corpse on her knees, etc. Special circumstances, however, modify the last peculiarity. The shock itself suddenly sometimes produces an amelioration, and then the person in his fright does make some effort at concealment of his act or some attempt at escape, but the reverse is the more usual.

One sees therefore that instead of murder being a rare crime, as it is among ordinary criminals, among the insane 54·5% of their crimes are of this nature, and if we add to this those of assault and violence, it will be seen that no less than 69·7% of the whole in those mentally deranged are crimes of violence, while theft, etc., instead of being nearly 36% is only 18 and of these, a perusal of the case will shew, that a large number are of a trivial nature, obviously performed without motive, or impulsively and suddenly of some worthless article that happened to take the insane's fancy.

Several other crimes of an unnatural and unusual character help to swell the list, such as destroying Telegraph poles, those of eating of a dead body, while the great infrequency of fraud and deliberate cheating and receiving stolen property is very striking.

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## COMPARATIVE TABLE OF THE CRIMES COMMITTED BY "CRIMINAL LUNATICS" AND BY THOSE REGARDED AS ORDINARY PRISONERS.

<i>Of all the (17,014) prisoners in the Punjab Jails for the year 1905.</i>				<i>Of all criminal lunatics in the Punjab confined from 1st Jan. 1900 to 31st Dec. 1906*.</i>					
				TOTAL 265.					
Murder ...	} ... 321	} = 3'3%		Murder, &c. ...	146	= 54'5%			
Attempted murder ...									
Culpable homicide and abetting suicide ...				254					
Hurt and assault ...	934	} = 12'46%		Do. ...	35	= 13'2%			
Aggravated do. and general hurt ...	1,201								
Suicide ...	33	= 0'2%		Suicide ...	5	= 1'9%			
Theft including theft in a building, by servants and by breaking open ...	2,577	} = 35'8%		...	33	} = 18'2			
Robbery and aggravated theft ...	143			...	2				
Dacoity ...	79			...	2				
Dishonest misappropriation ...	126			...	1				
Receiving and concealing stolen property ...	1,149			...	13				
House breaking and House trespass ...	1,997			...	2				
Criminal breach of trust ...	215	= 1'2%		Arson 4, Mischief 1 ...	5	} = 2'2			
Cheating ...	294	= 1'7%		Destroying Telegraph poles ...	1				
Mischief including arson ...	219	= 1'2%		Adultery ...	1	= 0'3			
Offences relating to marriage ...	332	= 3'1%		Abetment ...	8	= 3'0			
Bad livelihood ...	2,408	= 14'1%		Rape ...	2	= 0'7			
Rape ...	41	= 28'34%		Eating a dead body	1	= 0'3			
All other offences ...				Extortion by threat of death ...	1	= 0'3			
				Crimes not stated ...	6				

\* The insane characteristics in the list of crimes is well brought out when we consider that of the 146 cases of murder among a total of 265 Criminal insanes, 24 of these people murdered their own wives, 11 their own children, 14 their own father or mother, usually the latter, 11 the sister, brother or some near relation, and that 13 others murdered little children; that nearly all were sudden attacks of a brutal, revolting character, usually suddenly affected without provocation. These numbers could no doubt be materially increased, for the very scanty particulars formerly sent with each patient to the asylum, frequently omitted the details of the crime and in many this is not known and cannot now be discovered.

## CHAPTER XLI.

## MORAL "INSANITY."

THIS division of insanity has given rise to endless discussion, its very existence even being denied by many, and in truth, the correct name should be moral imbecility, as it is always congenital, the cases in which a man is morally insane, and is known to have been previously different, being always a condition resulting from previous insanity, or being a symptom of another mental disease. It is scarcely necessary to point out that "morality" is by many misconstrued and restricted to sexual relations, and that this partial use of the word is not intended here, but that its real and wider signification having reference to right and wrong, the ethical standard of living and just dealing, the maintenance of "justice, truth, purity and wisdom," subordination of our animal impulses and desires to that which is at any rate regarded among one's own race and period as right and wrong, and consideration for others, is that which is here referred to. "A moral sense" or "faculty" has been supposed to be innate,—in which case however it is a little difficult to see the necessity for any religious or moral teaching or discipline, but postponing the discussion of this point, every one will own that morality bears no certain relation to intellect; that this latter may be in some men of a very high order, and yet the person may be vicious and depraved. Many men of genius have been so, while it must also be acknowledged that the standard of morality varies in different races, and has done so in people of different ages. The undoubted fact remains, that it can be lost or appears to be lost in Insanes, and is certainly absent from birth upwards in some few instances. Such forming most of the class of instinctive Insanes described by writers on criminal anthropology. It is undoubtedly a very high mental development, and is only fully developed in adult life, and therefore in mental failure or alteration from disease, it is necessarily the first to fail, and one sees the fact in all insanes, who directly they become so, become from that fact selfish, lose all consideration for others, and do exactly what they please. Practically every lunatic is a potential criminal, the ordinary rules of conduct do not apply to him, and he is as likely to commit any crime or offence in response to some delusion, wayward impulse or momentary irritation, as he is to tear his clothes, refuse food, or perform any foolish act. Children in their early years are practically the same, the fiction of an innate

moral capacity notwithstanding, they all require training and guidance, some much more so than others.

What however is usually understood by moral insanity, is a condition in which a person will do any immoral act, lie, steal, injure, has no idea of *meum* and *tuum*, cannot be influenced by exhortation or punishment, and yet otherwise appears quite sane.

This condition may appear in a person who was formerly as well behaved and well conducted as others, and is then always a result of a former attack of insanity or a first symptom of one : and secondly, a person may be born deficient in this respect—as indeed are all idiots and imbeciles, though unlike them these true moral imbeciles are otherwise intellectually perfect.

(1) It is an undoubted fact that after any attack of insanity, in even so-called complete recovery, the patient is almost always left changed, it may be only in some trifling peculiarity, some social difference, the man being duller, less energetic or noisier, less industrious, less given to patient application, but a difference there always is, often so slight or unapparent as to be only appreciated by the more intimate members of his family. Most usually the difference is a "moral" one ; he or she is more easily put out, is less sympathetic, not so unselfish or thoughtful for others, the habits are not so refined, and there is a tendency to carelessness in general behaviour and in regard to others. There is a direct gradation from slight sequelæ such as these to the absolute loss of all moral sense, or loss of all power of control over the passions, the result of which may place the unfortunate being under examination as a criminal lunatic. It is only to these cases that the term moral insanity can be applied, and when one lays such stress on the fact of there being no *intellectual* derangement in them, it may be pointed out that it is an open question, if this very moral "emotional" insanity is not in itself a proof of impaired intellectual power, a loss of higher judgment and reasoning capacity. The moral sense—perfect self-control, whether we suppose it to depend on the innate brain quality of judging conscientiously with which we are credited, or whether it is due to the alternative supposition of obedience to general rules of conduct, founded chiefly on utility, the observance of certain conditions of life absolutely necessary for the maintenance of society, augmented by others originally founded on sentiment and traditions, the whole made up into a code of conduct of moral behaviour, enforced partly by legal enactments, and still more by universal approval or disapproval ; still, whichever view we may

take, it is always necessary for the firm establishment of this moral faculty, for it to be strengthened by training and confirmed by the approval of one's own conviction as to its good sense and necessity. Each of us has learnt our present self-control as a result of constant and prolonged religious and social training from early childhood, strengthened when we are able to think for ourselves, by the conviction of the necessity for its maintenance, from our own judgment and experience, and so the more highly this moral, mental and superficial polish has progressed, the easier is it to fall in any process of mental impairment, from the very fact of the maintenance of its high standard needing the constant exercise of a high grade of judgment and reasoning. Instances of such defect and of loss of controlling the instinctive emotions of rage and anger following on previous insanity are very frequent in insanes in India, and an excellent example is appended.

(2) A state of changed moral and social behaviour is very occasionally seen as almost the sole symptom after recovery from injuries to the head.

(3) Very similar symptoms are, however, seen in cases of simple mania, but in these the restlessness, the tendency to constant chatter, the inability to continue permanently in any occupation, the obstinacy, the peculiar sense of being always right, of well-being, the insomnia, and difficulty in inducing them to take sufficient food, and their history should serve to distinguish them. Such persons never believe themselves to be in the wrong and will easily make plausible excuses for any action they commit.

(4) Moral delinquencies may be seen in many cases of epilepsy, following either an attack of *petit mal*, or of the major variety, and as such people seldom have any delusions, and may appear intellectually very capable, a mistake is possible, but a short period of observation should enable this to be rectified.

(5) It has been noticed that some men of much phenomenal ability, usually however limited to one particular field, music, above all, and more rarely painting, and some other capacities are morally defective, these are cases which more properly belong to the category of congenital deficiency, before passing on to discuss which it may be remarked, that cases of crime as a result of loss of self-control and emotional disturbance are sometimes met with in the very early stages of general paralysis of the insane, so that although this disease is practically unknown in India, it is always as well to remember such a possibility.

In all these cases it is most important to enquire for the history of antecedent attacks of insanity, or for a family history of neurotic inheritance. Indeed, it is the opinion of many writers that almost all these cases of emotional or moral insanity are cases of sequelæ from cured (sic) attacks or are cases of chronic mania, with some "impulse" or other permanent emotional defect, marking them out ; generally it is said they are accompanied with a certain amount of mental exaltation. The cases of obsession or fixed idea, and still more, those of morbid impulse, differ from those of defective control above referred to, the former term being usually applied to these patients generally of neurotic heritage, who suffer from some constant, fixed (always the same), obtrusive idea or desire, generally accompanied by dread of it.

I have, however, seen instances of patients partially recovered from mania or melancholia whose chief symptom was a constant desire to commit some unjustifiable act ; it is very rare though that these are without some other sign (a delusion or hallucination) of chronic disease. These cannot be termed cases of moral insanity.

We have now been speaking of those instances in which patients suffer from a loss of moral sense, having once had it, but having lost it as a result of previous mental disease, but in the remaining variety, and this the most striking, are those the patients who have never had any moral sense to lose ; they are practically moral idiots, cases of partial developmental arrest with the animal propensities overriding the intellectual, young people who, as they progress from infancy to adolescence, fail to develop moral sense or feeling, there being an utter want of every good and honest sentiment, and an utter incapacity to perceive right or wrong. In the milder examples these are the *mauvais sujets*, the black sheep of so many families, who teach in such unquestionable terms the fact that vicious and virtuous tendencies are alike hereditary, and that each may be displayed from earliest childhood, in children subject to exactly the same educational and other influences as those who become utterly different.

In these cases the intellect is fairly developed and quite unaffected by disease, yet there will be complete moral perversion, the child bright, intelligent, indeed often precocious, growing up to be a vicious, ill-conducted lad, utterly unanswerable to all forms of education or discipline, perhaps, if in a lower station of life, developing into an habitual criminal, quite without any feeling of morality, and only actuated either by impulses or by

the most selfish, cruel and depraved motives. It has, indeed, been said to follow an attack of illness in childhood, such as hydrocephalus or scarlet fever, or an accident, such as a fall or blow on the head, but in the vast majority no such connection is traceable, and nothing beyond a neurotic heredity can be alleged as in any way likely to be the cause.

A fair proportion, it must be allowed, show some of the stigmata of degeneration, a high, narrow or keel-shaped palate, prominent ears, inequality on the two sides of the face, a high degree of myopia or abnormalities in the skull or limbs. This type is equivalent to the Instinctive Criminals of various writers.

It is obvious how likely these cases are to be regarded as ordinary *vicious* habitual criminals, from whom there is the greatest possible difficulty in distinguishing them, and indeed beyond the family history and the motiveless, purposeless nature of the acts they are constantly committing, there can be little else after we have carefully considered their history as a whole, that will aid us in giving an opinion, and each case must be decided on its own merits. Undoubtedly there is such a class of cases, and such a variety of imbecility, treatment with them is hopeless, no improvement is even to be expected when they have once reached adolescence, and the only remedy as a safeguard to others is their speedy seclusion within the walls of an asylum or a jail.

Moral "Insanity" is, therefore, either—

- (1) Moral imbecility (congenital).
- (2) Acquired as a residuum of previous insanity.
- (3) As an intellectual change after head injury and possibly insolation.
- (4) As a feature of Simple Mania.
- (5) As a feature of Epilepsy.
- (6) In the examples of one-sided Genius.

Case 1—Is a clear example of emotional insanity and loss of inhibitory power following on an attack of melancholia—the most frequent type of such cases—and is also a good example of emotional irritability or hyperæsthesia.

J., aged 35, admitted in August 1896.

This man is a Mahomedan cook, originally a camel driver, a resident of Multan, who murdered his wife in August 1895. No particulars as to the nature of the act or whether done under provocation are given, but as it is stated that he had been insane

since April and had been in consequence subjected to the usual native mode of restraint, *i.e.*, tied to a bedstead and had been so tied on the night of the murder, but had managed to "get loose," it is presumable that he did the act without provocation. The history of his insanity is very vague, the relatives' chief point being that he was always trying to injure his own head. He was detained in jail some six or seven months, and while there, was apparently melancholic, refusing to speak or only answering in a whisper, but at the same time being clean and coherent. On the whole, it may be safely concluded that he was suffering from melancholia. At the trial he was deemed insane and unable to plead and was in consequence transferred here. No family history of insanity, etc., is obtainable. Since admission he has shown no ordinary sign of insanity. He is a strong, healthy man, of usual appearance; he owns to the murder of his wife and is rather proud of it. He has perfect memory, answers sensibly and coherently, shows no delusions, works well, is clean, tidy, and obviously intelligent. He is, however, without any of the respectful bearing that might be expected from a man of his class; he has an insolent, defiant bearing and is very easily made irritable, and on the slightest provocation, or what would be none at all to a normal individual, he becomes uncontrollably violent, will listen to nothing, and quickly works himself into a most violent rage, talking rapidly and excitedly, using most foul abuse, all of which culminates in a murderous assault on the object of his rage. The conditions gradually became more and more marked from being slight at first, now being most pronounced, until he has arrived at being considered the most dangerous man in the asylum. In May 1900 he made an utterly unprovoked assault on a feeble *moharir*, and was only prevented by the attendants from strangling him. In August of the same year he got angry and attacked the head keeper in a most violent manner. After that he remained for about twelve weeks fairly quiet, and was so much improved that he was allowed to work in the weaving shed, but in the Spring of 1901, he quarrelled with another lunatic working in the same building; in a few minutes he fell into one of his old rages, and it is said assisted by another lunatic (Case 2), literally kicked the man to death.

Since then he has relapsed into his old condition, the least restraint, the slightest whim refused, he becomes violently excited, abusive, and obscene, only prevented by actual force from



committing murder, and obviously without any form of self-control. With all this the man is clean, decent, tidy, and when not angry, respectful, speaks sensibly and coherently with perfect memory and without delusions or hallucinations, sleeping and eating well and in perfect physical health. Superficially he gives the impression of pure viciousness, for he is an able liar, denies ever having assaulted any one or ever having given trouble, and complains loudly of not being treated like the other lunatics. From indirect evidence, however, there is no doubt that he does remember the details of rage, and he is certainly not epileptic. His chief characteristic is an extreme irritability, an absolute incapacity to control himself when in the least excited.

It must be remembered that a man of his intelligence knows perfectly well that having been certified as a lunatic there is no punishment that can befall him ; he may commit murder, but is quite aware that he will be acquitted on the grounds of insanity. He knows that he is in an asylum now, and, that being so, he has reached the ultimate resource of justice ; he is fed, well cared for, free from all anxieties, and is naturally absolutely reckless and regardless of any consequences of his actions, a condition which, however, it may be regarded, seems under the present condition of things to be unavoidable. As a matter of common prudence, he is now kept in a separate compartment, and it remains to be seen whether the condition of life is sufficiently irksome as to induce him to make any efforts to improve ; such, however, is extremely unlikely. (This man ultimately died of pulmonary phthisis, his peculiarities lasting up to a few weeks before death.)

The next case does not show these storms of violent rage, but is an example of the last variety of moral insanity from failure of development, and shows a condition of absolute reckless viciousness and complete absence of all moral or social feeling, so marked as to render it well worthy of description.

Case 2. B, admitted 16th August 1899, aged 22 (?).

This man is an habitual criminal, who has apparently never in his life maintained himself by honest labour. While in jail, for a term of imprisonment for receiving stolen property, he was found so constantly troublesome and given to making unprovoked assaults on the weaker prisoners, being filthy, and utterly unamenable to reason and punishment, that he was finally certified as a lunatic and sent here. Absolutely no previous or family history is obtainable of a reliable nature.

Beyond a certain amount of irritability he showed no sign of insanity, but he was soon found to be vicious, cruel and animal, disobedient and revengeful, tearing up his bedding if checked, and destroying the materials of his work if spoken to. It was considered that his conduct denoted him at that time to be more of a criminal than a lunatic, and he was discharged at the expiration of his sentence in December 1900, but his conduct obliging the authorities to put him under security, he was sent back to jail, and again later on transferred here with the same history (early in 1901), and since then his conduct has never varied. He is a tall, well-built young man of most repellent aspect, being thick-lipped, with one ear cropped, and his face plentifully scarred as a result of old fights and injuries. He is clean, tidy, without any of the usual signs of insanity, that is to say, he speaks sensibly, intelligently, and coherently, is without delusion or hallucinations, and works well and skilfully with application when it so pleases him. He sleeps and eats well, is not an epileptic, and is in good physical health. But he is, on the other hand, most vicious, immoral and unprincipled, a fluent liar, a thief, and though a coward, constantly found committing assaults on the weak and helpless lunatics. It is said that he assisted Case 1 to kick to death the man referred to; he is perpetually endeavouring to commit sodomy, always ill-treating and bullying the weak demented and idiots, and daily concerned in some quarrel or grievance which the others come to complain about, mischievous, disobedient, absolutely unreliable and uncontrollable, the perfect pest of the whole asylum, on whom no training, no kindness, persuasion or threats have the slightest permanent influence.

Now, this man's actions have all the appearance of pure viciousness; he has perfect memory, he lies to excuse himself or for some other end; he does not steal from a magpie love of collection, but with a definite end and purpose; he is grossly immoral and his acts of assault and cruelty are always on those weaker than himself, and not done out of pure insane impulse or in ungovernable passion. It is doubtful how much they are due to the failure of volition, for when caught and threatened with the deprivation of some privilege or the imposition of a punishment, he will remain for some days quiet and orderly, but the effect gradually wears off, and he again follows his old evil courses. In his case his general intelligence is of such a high order as to preclude the possibility of suggesting his act as due to imbecility or weak-mindedness. But it may be also pointed out that being so intelligent, it is reasonable to suppose that he

would exercise more self-control to escape from his present uncomfortable position, and his failure to do so is a very strong evidence of his insanity. He is certainly irresponsible and incapable of seeing things as others do, and his general conduct for ordinary public security and comfort renders it imperative that he should remain secluded either in a jail or a lunatic asylum; even though his history may always give different observers opportunities for debating as to which particular institution he more properly belongs.

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## CHAPTER XLII.

### HOMICIDE IN INSANITY.

ANY crime of any nature may be committed in Insanity, but the most frequent in this country and the one for which our opinion is most often called for is undoubtedly homicide. A variety of insanity has, indeed, been described under the head of homicidal mania, but, as a matter of fact, no pure disease of this character exists. There are, however, cases of subacute mania, in whom a constant impulse to kill and destroy is a marked feature, but this is only a variety of the impulsive acts so common among insanes and is in no way peculiar, and murder occurs infinitely more often in other ways. The general characteristics of an insane person's crime have been already referred to and need not be again enumerated. An insane may kill a fellow creature, (1) in a paroxysm of acute mania, in wild rage, (one man here in this condition stamped another patient to death with his naked foot because he found him asleep in the corner of the asylum garden, he was in the habit of occupying), or in his desire for destruction, or to show his strength and power just as he will root up plants and young trees, and tear to shreds his clothing and bedding.

(2) In the mania of acute *charas* intoxication, violent assaults are very common, and there is always afterwards complete forgetfulness of the act, so that no explanation of it is possible.

(3) An insane may commit murder as a result of delusion, believing, as do so many paranoiacs, that he is the victim of active persecution, or that some one is about to do him bodily harm, or that he is acting within his rights in self-defence, or even in duty

bound or in obedience to "voices" he hears ordering him to do so, etc.

(4) He may do so in melancholia with the idea of saving the person from some greater evil—wife and children from penury and disgrace, that he erroneously believes he is about to bring on them.

(5) Commonest of all in India as a result of what can only be termed chronic melancholia. The history usually given being that a man has relinquished his work, kept in his house for months, declares that he is ill, must die—very often that he has a burning in the epigastrium or disease of his "heart and liver," that he has been bewitched—he is constantly dejected, silent and miserable, keeping always to one place, usually huddled up in a corner, eating badly and becoming very irritable and passionate. Finally, one day either without provocation, or in response to some trivial annoyance, a crying child, lightly cooked food, etc., he starts up and murders in a brutal manner, wife or child or friend—and can give no explanation or only a very foolish one at best for his act, and what is extremely curious is that the large majority of such men after months of observation in an asylum or jail, begin to recover, to be bright, active and to eat, and always then assert that they have no recollection whatever of the murder, and this even though at the time of arrest they may have denied it—usually the blank in the memory extends to several months, and the statements are so uniform and consistent as to leave little reason for disbelieving them. A certain number of these cases do not recover, but remain always in their condition of brooding "melancholy."

(6) Murder generally of the infant may be committed in all forms of puerperal insanity, and it may be and often is done.

(7) In the blind unconscious fury preceding or following an epileptic paroxysm. Of this too no memory ever remains afterwards.

I have also once seen a cause where a man murdered another (case 132) in the delirium of pneumonia quite unconsciously, and I have met one case of serious homicidal injury inflicted during somnambulism. All these present no difficulty of recognition and do not need separate discussion; there are, however, others when the plea of insanity is suggested, and the patient on examination shows no signs of intellectual derangement and gives no history of such, and these need very careful consideration.

It will be found that these belong to two classes: (1) the very rare cases of so-called impulsive Insanity; and (2) cases of so-called moral Insanity.

The first class comprises a certain number of patients who complain of an influence that overwhelms them, a frantic desire to eat, kill, steal, to fire, who say that they have an overpowering impulse to commit murder, or it may be any other crime, suicide, theft, arson, or some bestial act, an idea so morbidly vivid, that the will is powerless to arrest it, though they may declare that they struggle against it, that they know and recognise its proper nature, (and in this the patients differ from so-called moral insanes,) that they had struggled successfully for some time, even in some cases people having sought protection in an asylum against themselves, but that finally the desire, their impulse, their overmastering propulsion, perhaps aided by the sight of some weapon, or the recognition of a sudden opportunity, has obliged them to give way. These cases remember all the details of their crime (unlike those referred to as cases of chronic melancholia); do not, as a rule, try to escape the consequences, nor do they perform the act in the automatic unconscious manner as do epileptics, nor even as in the form where a homicidal fury takes the place of an epileptic attack, the "marked epilepsy" often described. They are exceedingly rare in India. Generally, these cases, if careful inquiry be made, yield a neurotic family history, of insanity, convulsions, epilepsy, or degeneration, and this is of very great importance in leading one to form an opinion, while so much the more is that of precedent insanity in the patient himself, but then it is always difficult and usually impossible in this country to get any family history of a reliable nature. One may be indeed reduced to an examination of the facts of the crime itself, when the patient shows at the time of scrutiny no discernable intellectual derangement, to estimate whether this is of such a nature as in itself to give a strong presumption of insanity, which indeed sometimes happens; the murder of some near relation, child or sister, known to have been much loved, in cold blood without a motive, without a quarrel, unaided; in the presence of witnesses even, or it may be in a particularly diabolical manner; the suddenness, uncalled-for, causeless nature of the act, the absence at all attempts at explanation, motive and afterwards (though this only sometimes) of all efforts at concealment or escape, taken with the prisoner's own behaviour, and considered in reference to his history and character, as being totally at variance with such a crime, may all give good grounds for the opinion that the act was one for which the prisoner was not responsible, and may be the clearest evidence of his insanity. It is

above everything most important to enquire for the man's previous history, as there is little doubt that in the vast majority of these cases, there *has* been an attack, even if only a slight transient one, of melancholia or mania, and that these cases are really only varieties of chronic mania, markedly characterised by insane impulse as their leading symptom. Excluding such individuals there only remain those affected with pure moral insanity or rather imbecility, a disease in which patients normal in dress, bearing, speech and appearance, and able to reason with full intelligence or without delusions, are totally deficient in moral sense, and will commit any crime or some particular one, for which they have a natural predilection, from the normal power of inhibition being wanting, and the emotional impulses in full and excessive activity a reversion to the infantile type of mind characterised by utter loss of control; instincts, passions and desires, all being without any inhibition. This variety of mental disease is, however, discussed in a separate chapter.

With these cases must also be included those of emotional hyperæsthesia, if I may term them so, that we not infrequently see in an asylum here, men having their passions on the surface, in whom the least provocation, the smallest irritation, however accidental, trifles that would be passed unnoticed by a sane individual, immediately result in a frightful outburst of passion or rage, a violent emotional storm, a rage in which no sense of right or wrong, of obligation, gratitude, or affection will restrain the man from committing murder or deadly injury, the height of the emotional wave being such as to render the desire for some action as an end so powerful, as to be quite uncontrollable by any other idea or any effort of judgment that may oppose it. Such men are almost always instances of chronic melancholia, resembling much those already referred to (class 5), and in support of this belief, it will be found that the large majority of these latter cases are the result of some previous mental disease, usually melancholia, that the patient has suffered from, it may be years before and from which he has recovered with this lesion of the moral sense or the defective power of inhibition as a permanent defect. Indeed, it is questionable whether this condition can ever arise in an adult who has been previously endowed with as much power of self-restraint as ordinary people, without some precedent attack of insanity to cause it.

The insanes in any of the classes 1 to 7 present such obvious

signs of mental disease as to afford little difficulty in diagnosis. It is difficult to say which variety is the most dangerous—the most common, in my opinion in India, are cases of class V which I have termed chronic melancholia, but those of *charas* intoxication or mania are always frequent, such persons are in a state of wild, furious, restless activity, and seem to be actuated with a desire to kill, strike, slay, that is almost incredible to those unacquainted with the effects of the drug; in this and in the complete amnesia for that period, they resemble patients with epileptic fury, who will also in a blind, furious rage attack and kill anyone without the slightest provocation, and are usually looked upon as the most dangerous of all insanes; they are not so, however, in this country. The frenzy resulting from Indian hemp producing just as wild and brutal actions.

The cases of paranoia (chronic systematized delusional insanity) with delusions of being persecuted by some one or some class of persons, are equally dangerous, but in a different manner; they will carry concealed weapons, knives, pistols, about them, and suddenly murder an unsuspecting person in obedience to the idea or in response to an hallucination. Such have complete memory of their crime. In certain cases of alcoholic mania, the patients are also liable to make sudden murderous assaults, though sufferers from *Delirium Tremens* generally prefer to commit suicide.

Idiots and imbeciles very rarely commit violent assaults; they are generally more destructive than actually dangerous, cruel than violent, but given an opportunity, they may injure or even kill little children or helpless individuals weaker than themselves.

Infanticide is not a common crime in this country, the estimation in which children are held, the interest taken in their birth, usually results in the mother being rarely left alone at that time. The parent is usually extremely desirous of having them, and therefore the murder of her own child by a native woman is in itself very strong presumptive evidence of insanity.

An insane mother may, however, be delivered without being fully conscious of the fact, and the child may be accidentally killed in consequence. In the acute form of mania that sometimes arises immediately after delivery, a woman unwatched may very easily kill her own child without any premeditation, and there may be also very little memory of it afterwards. Indeed, in all varieties of insanity occurring at the time of childbirth there is a peculiar danger in this respect, and no child should be left with a mother

unwatched under these circumstances, the mothers frequently, indeed almost always, having a strong dislike to it, and to her husband, or having some delusion that may cause her to murder it. Even if they do not attempt murder at the very best if melancholic, they neglect it, and if maniacal they are rough, heedless, and careless, and very serious injury is more than probable. The child should always be handed over to the care of an attendant.

*Note.*—Though poisoning may be said to be the rarest of all acts of insanes, an instance of such an occurrence in a woman is referred to by Dr. Blanford, *Insanity and its Treatment*, p. 346. And one is also given in the cases recorded in this book.

*Note.*—As everyone is aware, there are certain districts in this country where the female children for reasons connected with their marriage in later life are very frequently murdered, or at any rate allowed to die. The habit is well known to exist, and the question of insanity in extenuation is scarcely likely to be raised, and could never be maintained in the rare instances in which such cases are ever likely to be discovered.

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#### SUMMARY OF CASES OF CRIMINAL LUNATICS CHARGED WITH THIS CRIME IN THE PUN- JAB SEEN FROM 1900 TO 1906.

##### 1. Z. K., admitted 5-12-91, at age 30.

This man was sentenced to transportation for life on 15-1-91 for murdering a man by stabbing him in the stomach.

It appears that he had been twice previously convicted for assault, and that he was notoriously a man subject to violent fits of rage, who seemed to be able to work himself up into a condition of fury in which he lost all self-control. It appeared that Zulfakar Khan was present at a wedding. Two little boys in front of him quarrelled, he boxed the ears of one, and on being expostulated with for doing so by another man, drew out a clasp knife and stabbed this man three times in the abdomen. The man died from bleeding.

During the trial he had a fit of violent rage, but except for that never spoke and has from that day to this 30-1-08 never opened his lips.

He understands perfectly everything said to him. Will not work, remains of his own accord in a separate room, which like himself he keeps extremely clean. Though very quiet and respectful in manner, nothing will induce him to speak. Of late years he has taken to writing requests and statements on the walls or slips of paper, in excellent Persian and Urdu. In these he states that a Farishta sent by God was always talking in his ears, and that he was obliged to obey his orders; other letters simply contained requests for various luxuries. But during the last two years these have become very incoherent and wandering. Not only, however, has this man not spoken for 17 years, but he is subject to very violent fits of rage on the most trivial provocation, and then seems to have uncontrollable impulse to stab especially, if possible, in the face.

Thus on the 12-7-05 he attacked another lunatic most murderously with a nail for having thrown some dirt on him.

On 15-10-01 he made a violent assault on another with a nail concealed in his hand, obviously intending murder; provocation was very slight.



- 12-4-02. He made a murderous assault on a talkative lunatic, stabbing him with a sharpened piece of bone which he had concealed by him. The day before he had suddenly attacked (with a sharpened piece of wood that he had torn off the lintel of the door) an attendant who came into his room with the barber to shave him. On all these occasions he was perfectly silent.
- 20-2-03. Suddenly attempted to stab (he succeeded in making a flesh wound) another lunatic (in the face) with a sharpened piece of bone which he had secreted. Apparently in a rage at the man taking some chunam off his wall, though he never spoke.
- 8-9-04. Stabbed another lunatic with a sharpened piece of wood.
- 2-9-05. Attacked another lunatic Dhumei with a sharpened bone. The provocation was given by Dhumei about 10 days before the attack, he having thrown some mud in Zulfakar's cell.
- 18-9-06. Assaulted another lunatic who was making a noise. This time hitting him on the head with a brick. During the intervals he is quiet, clean and modest, and does not alter in the slightest.
1908. Still in Asylum and unaltered.

2. A. B., Musalman. Age 26. Admitted 19-1-04. Class I. Section 302. Delusional melancholia.

Charged with the murder of his wife. No particulars received except that he attacked his wife twice before the occurrence.

- 24-3-06. Says he shot his wife with a gun—jealousy on account of his wife's behaviour. Father died of fever. Brother of syphilis. No members of family insane. He complains that J. A., brother of patient's murdered wife, has taken away her jewellery.

DURATION of present attack 6 months.

A strong, stout, well-made young man. Black hair, frowning, staring, frowning look—easily becomes excited. States that his condition is solely due to the persecutions of a Fakir he had offended, because he had gone to a rival man to help him in a love affair.

SPECIAL SENSES. Perfect.

SLEEPS Well.

SPEECH. When excited is rapid, a little discursive but very sensible. He owns to having committed murder, and offers no excuse, nor does he express any remorse; he is very definite as to the certainty of dying in two days, and as to his hallucinations; asks for a power of attorney to be made, so that the poor may have all his belongings.

ATTENTION. Good.

REACTION TO QUESTIONS. Replies, except on the subject of his delusion, quite sensibly; he is liable to become excited if questioned.

COMPREHENSION OF QUESTIONS. Understands perfectly.

MEMORY, RECENT. Good.

MEMORY, REMOTE. Good.

DELUSION. Though obviously in good health, states that he is about to die and cannot possibly live more than 2 days, on account of a Fakir reading the Koran over him—he having been disrespectful to him—to all, he has to die, "to answer by the Koran."

He also states that day and night the Fakir comes to his cell and beats and ill-treats him, and that he has done so for 16 months.

SUICIDAL TENDENCY. None.

HOMICIDAL Do. States that he has committed murder. Obeys, silent. Attitude, natural, clean, modest, not destructive.

11-2-04. Much better, does not now talk of certainty dying, very good tempered and amiable.

9-3-04. Very fat, no longer talks of his delusions.

12-4-04. Now declares that there is no hope for him, he must die—obstinate.

9-5-04. Always same delusions, that on account of his disrespect to Fakir, he is persecuted, and that he must die—asks to be allowed to be buried alive.

3-6-04. Usually very despondent—as though on the point of tears—works a little—still same delusions.

2-7-04. Always the same.

4-8-04. Says that he is continually being ill-treated by the Fakir and that he suffers terribly.

7-9-04. Same delusions constantly, always complaining how weak and ill he is as a result of the Fakir.

4-10-04. Delusions unaltered.

27-7-05. Wants to have his case sent on to the Fakir, who will pardon him.

19-8-05. As last month.

21-9-05. Unreasonable, will not work, continually in wet clothes from which he had got an attack of eczema.

25-10-05. Does not alter—same ideas. Has a curious habit of constantly washing his face; indeed, it is seldom dry in hot weather, so that an eczematous condition has been induced by this habit.

24-3-06. This man has distinctly improved, if he has not actually recovered. He states to-day the reasons he had for killing his wife, how and why he did it; he says he was quite sensible at the time.

19-4-06. At the present he is just as certainly insane, is talking rubbish about fakirs, etc.

24-5-06. Delusions; constantly drinking water and washing himself; every quarter of an hour or so shouts out Allah.

26-6-06. Always the same habits.

27-7-06. Always wet; constantly splashing himself with water, apparently with the idea of cooling himself. Mental condition unchanged.

1-11-06. Delusions are absolutely unaltered.

15-4-07. A most intelligent worker, but always sighing and calling on Allah. Delusion unaltered.

30-1-08. Absolutely unaltered.

8. S. M., Pathan, age 35. Admitted 20th April, 1905. Class II, Section 302, I. P. C.

CHRONIC MELANCHOLIA. On the 7th of December 1898, this man was convicted of murder under Section 302, I. P. C., and sentenced to death—subject to confirmation by High Court. The latter acquitted him on the grounds of unsoundness of mind at the time of commission of the offence. He was then ordered to be confined under Section 471, C. P. C., until further orders by the Local Government. He was sent to the Lahore Central Jail. From March 1899 until April 1903, exhibited no sign of insanity, worked his full task well: behaved very well, but late in that

month he refused to work. In January 1904 it is stated that he exhibited slight signs of insanity, but these are not defined.

In June 1904 it is remarked that he is eccentric in manner, but quiet and well behaved. He had recommenced work. In January 1905 it is remarked that he is "eccentric," morose, quiet.

**CERTIFICATE.** "Morose, endeavours to hide behind walls, or to sit in corners. Has taken a violent dislike against a fellow prisoner who has in no way provoked him *nor* has had any connection with him, and he threatens openly to take the latter's life." Has assaulted a fellow prisoner without provocation and so far as (by others) can be ascertained without any cause whatsoever. Is moody and melancholic. A pock-marked middle-aged man, with a foolish face, very respectful and sensible.

**SLEEP.** Good.

**SPEECH.** Natural.

**ATTENTION.** Good.

**REACTION TO QUESTIONS.** Good.

**COMPREHENSION OF QUESTIONS.** Good.

**MEMORY, RECENT.** Good.

**MEMORY, REMOTE.** Good.

**DELUSIONS.** None at present.

**SUICIDAL TENDENCY.** No.

**HOMICIDAL TENDENCY.** Yes. Obeys, will work, is silent, very respectful, attentive, clean, modest, not destructive.

24-5-05. Has shown no sign of insanity since his admission to asylum.

27-7-05. Quiet.

19-8-05. Sane.

29-9-05. Sane.

25-10-05. Foolish. Memory defective. Has distinctly altered.

22-11-05. Quiet. Unaltered.

20-12-05. Works a little. Obstinate.

23-1-06. As last month.

24-2-06. Still stupid and foolish.

24-3-06. Sullen. Morose.

24-5-06. Wants to go back to jail. Works as a weaver.

20-6-06. Sullen. Morose. Does not alter. Movements suspicious.

24-7-06. No change.

28-8-06. Replies intelligently to questions; but is sullen, says he would rather go over the "kala pani" than to jail, and says his feelings about the heart tell him he is insane.

22-9-06. Still "suffers" about the heart—no change.

1-11-06. Same delusions about madness being in his chest.

21-12-06. Delusions of some illness always.

21-6-07. The same.

18-2-09. Works as a weaver well.

7-3-07. Same delusions.

10-4-07. Wants to go on a pilgrimage. Speech coherent.

#### 4. P., Hindu, age 50. Admitted 4-4-05.

Class II. Section 802.

**MANIA.** Has suffered from attacks of "madness" at intervals since the age of 15. These followed periods of religious devotion during which he offered sacrifice to Devi; when the attack commenced he used to run about shouting "Jai Devi." The attacks lasted for from 6 to 20 days.

In 1896 he killed his little son in the morning (the son had been sleeping in the same room), battering his head against the ground, shouting "Jai Devi," "Jai Devi." He had then only just returned from a religious festival.

The Sessions Judge at Delhi, before whom he was brought up, acquitted him on the ground of insanity, but ordered his detention in jail, pending orders of Local Government, who eventually directed his being retained in jail until further orders. While in the Central jail he has behaved well and worked quietly for 8 years until quite recently. Father who is dead, said to have been "insane."

**SUPPOSED CAUSE OF PRESENT INSANITY.** Religious worship of "Devi."

**COPY OF CERTIFICATE.** By Superintendent, Central Jail. (1) Without any provocation became suddenly and violently excited in the workshop on the day of my inspection. (2) Has since had outbursts of passion and fury. (3) Attempted to strangle a fellow prisoner whilst the latter was sleeping.

**PREVIOUS ATTACKS OF INSANITY, DATE AND DURATION.** Since the age of 15 numerous attacks. The most serious being one in 1896, during which he killed his child. The attacks are said to last 7 to 20 days.

A man of middle age—with a small face and head and markedly extended ears.

**DEFORMITY.** None. Teeth very irregular, left upper central incisor, very prominent.

**TONGUE.** Fissured, markedly on the right side in front.

**SLEEP.** Good. Speech, intelligible. Attention, good.

**REACTIONS TO QUESTIONS.** Good. Comprehension of questions good.

**MEMORY, RECENT.** Good.

**MEMORY, REMOTE.** Good.

**OBEDIENCE.** Good. Willing to work a little, quiet, clean, modest, not destructive.

26-4-05. Working quietly in mat factory, simple-minded, fairly sensible.

8-5-05. On the afternoon of the 2nd, time between 3 and 4, the keeper of the mat factory was lying down in the mat shed (? sleeping), when Pultoo is said to have come and struck him three times over the shoulder with a piece of wood, bruising the shoulder and arm (right). The keeper sprang up and remonstrated with Pultoo, others of the mat-making gang coming to his assistance. A scuffle ensued in which Pultoo seems to have been severely dealt with, as he died shortly afterwards. *Post-mortem*—Fracture of and hæmorrhagic effusions into pleura.

5. Y. G. K., age 36. Admitted 26-9-05. Mania with homicidal impulses.

Convicted before Sessions Judge, Derajat, of murder on 18-5-03 and sentenced to transportation for life; later, while in jail on 22-6-03, he killed a fellow convict without provocation.

Affected with "Homicidal Mania." Is awaiting trial for having killed a convict in the jail, at that time he being under sentence of transportation for life. It has been noticed that he is incoherent in speech, is unable to concentrate his thoughts and at times weeps and laughs intermittently. He remains for hours in one position, picking imaginary lice out of his clothes, and occasionally strips himself. At times he is restless at nights.

While in Bannu jail, attempted to strangle himself with a rope made out of a blanket.

A very tall, fine made man; with luxuriant straight black hair. A miserable perplexed look. Has no deformity or paralysis.

**SPEECH.** Scanty. Very difficult to engage him in conversation. Generally he sighs and makes some irrelevant remark, or says that I do not know, or I do not understand even to the simplest question.

**ATTENTION.** Difficult to engage.

**REACTION TO QUESTIONS.** Answers, but stupidly.

**MEMORY, RECENT.** Professes to have no memory, and not to know when he went to prison.

**DELUSION EXALTATION.** None.

**DEPRESSION.** None except that he states that he has been unjustly arrested.

**SUICIDAL TENDENCY.** Even on the journey attempted to hang himself.

**HOMICIDAL** " Convicted of murder and also murdered a fellow prisoner. Obeys when he can be made to understand.

**OCCUPATION.** As yet nothing.

Silent, stands miserably silent to one side. Not filthy, modest, not destructive.

8-10-03. Very unreasonable. Complains that he has done nothing. Has been quiet since arrival.

11-12-03. Now working quietly with Durzi, but for three days was very restless. Would do nothing. Silent the entire day.

8-1-04 to 24-2-06. Sane.

24-3-06. Developed an attack of furious mania on the morning of the 22nd. For a few days before, he would not eat his food, behaved suspiciously, suddenly threw off all his clothing, became very excited, had to be kept apart. Still somewhat excited but much better.

19-4-06 Improved : almost sane again. Will not work.

24-5-06 to 1-11-06. Sane.

21 12-06. Sane? This month he has been quarrelsome and obstinate.

26-1-07. Sane.

18-2-07. Sane.

7-3-07. Sane? This man is very ready to join in any quarrel.

15-4-07. Obstinate and insubordinate : refuses to work.

**G. J. C.**, age 25, a private in 2nd Bat. Gordon Highlanders. Admitted 26-6-03. Delusional Melancholia, following exposure to sun.

Charged with having stabbed a punkah coolie on the night of the 11-5-03. He had been previously healthy up to an attack of Sunstroke in April 1902. On 9-4-03 he asked for his rifle and went towards the married quarters, but was restrained. Was very restless and strange. 10th May, after convent service, he knocked the gharry driver down and began to kick him.

9-7-03. Acquitted on ground of insanity. Father died at age of 65, Pneumonia, never insane and never suffered from fits. No history of insanity in family; mother living, 40/50. Five brothers, all healthy. One died, cause not known. Three sisters, one died unmarried. No one in family ever insane or epileptic.

**CAUSE OF INSANITY.** An attack of sunstroke on the march to Murree, 1902.(?)

**PREVIOUS ILLNESSES.** Had measles when a boy, no malaria.

**SYPHILIS.** No.

**INTEMPERANCE.** Occasional bursts, but none for some time preceding May 11th.

No previous attacks of insanity. Sunstroke on march to Murree, April 1902.

In Hospital till end of May. On the march he stripped himself in the guard tent, rubbed himself with sand and water, when told to dress, said ground was not steady and that he had no socks.

**DURATION OF PRESENT ATTACK.** Since April 1902.

A strong healthy-looking man, light hair, blue eyes, freckled.

**SLEEPS,** naturally. **SPEECH,** perfectly natural, except when he describes attacking the punkah coolie, "because he could not help it"—feeling as though he "must," as though a voice or "something" told him to do it and he could not resist—that it was the duty he owed to his forefathers—could give no explanation of this. Answers with reluctance but perfectly intelligently. Understands perfectly.

**MEMORY, RECENT.** Perfect.

**HALLUCINATIONS, SIGHT AND HEARING.** Of hearing a voice on 11th May, telling him that he must attack this man, feeling that on account of his forefathers he attacked this man, they many having ill-treated his forefathers, he struggled against it, but could not overpower it.

Obeys, will do anything he is told, but is disrespectful, yet is clean, modest, not destructive.

29-6-03. This is a fine, well-made young man with ruddy hair and neat bearing—he is extremely quiet and reticent, very reluctant to answer any questions, and curiously wanting in respect, such as one would expect from his station. He apparently takes no interest in anything, and asks for nothing, and does not occupy himself in any way, though he walks about for exercise and always gives one the impression from his manner and appearance of being in deep thought on some subject.

He is not violent now, obeys, is clean, tidy and decent. On being questioned, he admitted attacking the coolie from an unavoidable impulse. Felt as though he "must," that a voice told him to do so or "something" like a voice, as a duty. He denied any expense on drink on that evening, admitted that it was not a warm night, but that he felt restless and unable to sleep, and that of a sudden this impulse came on him. He states that he has never subsequently had a similar feeling. He denies any attack of epilepsy or any loss of consciousness, and states that for some time before 11th May he had quite given up all drink of any kind.

30-6-03. This man sleeps very heavily—he eats well—always extremely quiet and even taciturn, does not occupy himself in any way. He is singularly wanting in any of the respect usually found in a soldier.

9-7-03. Tried at the Chief Court, found guilty, but acquitted on the ground of having committed the act while insane.

25-7-03. Excited last night, showed violence towards his attendant. This morning he went back to his room after taking some exercise, ate and drank his own Chota Hazri as well as that intended for his companion A. then passed water into the tea tumbler, covered it over with a saucer and left it. Very strange in his behaviour, excited and almost defiant.

27-7-03. Remembers acting as he did, but states that he does not know why he did it. All day yesterday was alternately laughing and crying.

15-8-03. Attempted an assault on a punkah coolie at night, who was not pulling properly—hitting him with his boot in a very violent temper.

25-9-03. This man is always very taciturn, takes not the slightest interest in anything, and very rarely speaks on his own initiative. He will do nothing but spends the day silently,

smoking, sitting, or lying. Eats fairly well. Becomes most passionate over trifles. While having a tooth extracted he suddenly violently struck the Deputy Superintendent's arm away and with every appearance of extreme passion refused to allow him to proceed. Offers no explanation of his conduct beyond vague remarks as to not knowing, "could not say," etc.

From December, after suffering most of November from ague, to end of February he seemed practically sane and worked a little in the garden, but in the next month it was noticed that he was as before, liable to violent outbursts of temper, and that also he was silly and curious in his manner, very heavy, dull and difficult to manage.

When questioned, he made long pauses before replying, and then only did so by blurting out some monosyllable, and would never engage in active conversation. He remained to the last, clean and decent, and was finally, by order of Government, transferred on 19-3-04 to Bhawanipore Asylum, preparatory to being transported to England.

7. G. D., Hindu, age 38. Admitted 23-6-05. Class III. Section 307-326 I. P. C., chronic insanity, with delusions terminating in a moral perversion.

Sentenced on March 5th to 5 years R. I. (3 months S. C.) and admitted into Multan Jail: there he declined to work or did bad work, and was punished daily in every conceivable manner, including stripes on two occasions. Received an additional sentence under Section 52 of Act IX of 1904 for not working. He constantly refused his food, and behaved in an insane manner as is only too evident from his jail record.

He was transferred to the Montgomery Central Jail, where he continued to behave as above, and to be punished accordingly. In October the Superintendent ordered him to be kept apart on suspicion of insanity. Eventually he was considered to be insane, and the matter reported accordingly. He was admitted here on June 25th, 1905. He gives a long rather rambling story of his ill-treatment in jail, *i.e.*, says he never committed the crimes of which he was accused, and that there was a conspiracy among his family against him. (A brother is a cripple from the results of extensive infantile paralysis.)

No family history available.

Four children—two dead.

SUPPOSED CAUSE OF PRESENT INSANITY. Unknown.

- (a) He is generally in a state of nudity; constantly writes extraordinary statements on the wall of his cell, or bits of paper or rags torn from his clothing. He brings all sorts of frivolous charges against jail officials.
- (b) He uses abusive language; says he is a prophet sent by God to direct the affairs of men. He destroys his clothing and the various vessels supplied to him. Has on more than one occasion rubbed excreta over his body and on the walls of his cell. On one occasion threatened to commit suicide. On another threatened to assault any one who came near him.

A well built, well nourished man, clean shaven head, and face with a troubled expression, talks volubly and forcibly on slight provocation.

DELUSIONS—Sleeps well. Speech natural, coherent.

- (1) *Of Persecution*, *i.e.*, family are plotting against him.
- (2) *Of Disease*. Gleet—of his loins being broken into little pieces, etc.

May work a little, noisy, respectful, modest.

19-8-05. Constantly complaining about officials; exalted in his ideas.

- 21-9-05. Asserts that he, if let out, could put his hand on large sums of money which have been buried in various places by thieves whom he was in jail with. Very fond of writing numerous letters, which, as a rule, contained warnings or imputations against some one or other of the officials.
- 25-10-05. Unaltered.
- 22-11-05. Never alters, always petitioning against the staff.
- 20-12-05. Constantly petitioning.
- 23-1-06. Always complaining, very unreasonable.
- 24-2-06. As last month.
- 24-3-06. Unaltered.
- 19-4-06. The same.
- 24-5-06. No alteration.
- 20-6-06. Will not work.
- 24-7-06. A very talkative chronic maniac, always presenting petitions for release. "Has a lot of money."
- 28-8-06. A chronic, but the reverse of a passive resister, always objects to everything.
- 22-9-06. No change to record.
- 1-11-06. Writes and speaks sanely, but is vicious and unreasonable, badly behaved. Delusions not discoverable at present.
- 21-12-06. Now working and obeying orders.
- 27-1-07. Working well and obeying, but still scheming and talkative.
- 18-2-07. Scheming and full of wickedness. Sane.
- 7-3-07. Wicked, unprincipled.
- 5-4-07 to 30-1-08. A plausible unprincipled man. A skilful thief who concocts each day some false charge against someone, always writing.

**B. A. R.**, age 30 years. Admitted 16-12-02. Delusional insanity following on acute mania.

The relations give a vague account of the man having become insane since June 1902, with delusions of persecutions, and especially that his wife's father was anxious to kill him. In July he suddenly murdered the said wife by cutting her throat—giving no reason.

On admission to jail he was morose, melancholic, had delusions of persecution and frequently refused his food. The paralysis only commenced very gradually in November.

**FAMILY HISTORY.** No information available. 6-1-03 said by Police that his maternal grandmother's sister was insane.

**CERTIFICATE.** He refuses to eat his food. Is dirty in his habits, abusive and filthy in his language, and incoherent and maniacal in his conduct. That he is subject to delusions that he is going to be murdered and is sleepless and refuses to eat his food which has to be given forcibly.

"First attack" was under treatment by native Hakims at Delhi during June last, and after that at Rai Bareilly.

**DURATION OF PRESENT ATTACK OF INSANITY.** Less than 3 months. Very emaciated, yellow anæmic complexion, grey hair, lively, vivacious manner—very ready to speak English.

Can only walk with lower legs flexed on thighs. Loss of power of extension of both thighs—wasting of all thigh muscles, but both knee jerks are rather increased with no ankle clonus, and perfect control of sphincters.

**SPECIAL SENSES.** Perfect. Skin cold and livid, greyish yellow colour, extremities livid. Pupils—equal.

**PUPIL REACTION.** Equal and normal. Size, small. Speaks English in a rambling, disconnected manner. Denies any crime or that there is any



reason for his coming here—states that the C. S. of Delhi was bribed to kill him and keep him there, and that is why he was sent here.

Loss of power of extensor thigh muscles. Attention, perfect, replies at once sensibly to questions, but very difficult to get any history out of him. Understands anything said to him.

MEMORY, RECENT. Good.

MEMORY, REMOTE. Thinks that "some people" in prosecuting him, put him into prison and wished to kill him.

SUICIDAL TENDENCY. Nil. Obeys, but is quite helpless. Sick, does nothing, shows no desire for occupation. Silent. Still, with legs crossed. Self-satisfied, cunning expression. Not filthy. Modest. Not destructive.

EMOTION. Difficult to make excited—does not weep or exclaim.

22-12-02. This man has to-day for the first time eaten food himself, up to this he has absolutely refused to eat, saying he did "not want to"—he is continually complaining that Superintendent, Jail, Delhi, was bribed to keep him in, and making vague allusions to "damned rascals," who are enemies against him. It is impossible to get any detailed history of his illness from him. On the 19th he suddenly became collapsed and for about an hour his pulse was imperceptible. He recovered under the use of hot bottles to his extremities—strychnine and stimulants.

27-12-02. Denies all knowledge of the murder; rapidly becomes very abusive, if questioned. Paralysis stationary. Has power over his secretions. Again refusing his food.

23-1-03. It is now impossible to obtain an answer from this man. It is necessary to feed him through a nasal tube. When awake, he spends the entire time muttering and whispering obscene abuse. It is impossible to arouse him or to make him stop. He simply turns his head from side to side and continues muttering when addressed.

The attendants state that his language is almost restricted to the three words "bainchuet, suer sala," and that he continues repeating these even while being fed.

14-2-03. Exactly the same—still has control over his sphincters.

12-3-03. No physical or mental change—never uses any other words but those of abuse—still requires to be fed with nasal tube.

21-4-03. Has passed the whole of the month in exactly above condition.

20-5-03. Absolutely unaltered.

1-7-03. Condition stationary.

3-8-03. Always breaks out into the same abuse at the sight of anyone—still has to be fed.

9-9-03. Absolutely the same.

8-10-03. Very emaciated—otherwise unaltered, still requires feeding.

10-11-03. Extremely emaciated. Still repeats the same three words.

11-12-03. Condition unaltered.

8-1-04. Exactly the same. Still has to be fed by the nose.

11-2-04. No longer abusive—appearance brighter and more sensible.

9-3-04. Much better, fatter.

11-4-04. Now does not speak, still has to be fed forcibly.

9-5-04. Brighter, and more easily aroused, still will not speak.

3-6-04. Brighter, improving physically. Reflexes less excessive.

2-7-04. Still has to be fed by the nose.

4-8-04. Still has to be fed.

7-9-04. No longer abuses anyone—never speaks, prays regularly and washes himself, still has to be fed. Scorbutic.

- 4-10-04. Seems to be regaining power of movement. Will never eat.  
 3-11-04. Much improved—eating—beginning to walk, says his prayers, but will not speak—seems as though trying to do so but stops.  
 7-12-04. Now walks, eats well by himself. But will not speak.  
 7-1-05. Much improved—will not speak.  
 17-2-05. Clean, well behaved—working with durzee sensibly, but will not speak.  
 27-3-05. Unchanged. Refuses to speak.  
 26-4-05. Improved, muttered a little—rather incoherently indicating that he felt better.  
 25-5-05. A fortnight ago his father came to see him and he then began to speak rationally and coherently, and has since continued to do so. Gave as a reason for not speaking that he had an order from God.  
 16-6-05. Much improved, working well.  
 27-7-05. As last month.  
 19-8-05. Improving, still sensible.  
 21-9-05. Sane. Remembers his crime, but cannot give any reason for it, except that he was "behosh" at the time.  
 25-10-05. Sane.  
 22-11-05. Sane, but somewhat foolish at times.  
 20-12-05. Sane.  
 15-1-06. Left to stand his trial.  
 22-2-06. Returned, having been acquitted on grounds of insanity (Class II).  
 24-3-06. Sane.  
 19-4-06. Sane.  
 24-5-06. Sane, working in office as a clerk and doing very well.  
 20-6-06. Sane.  
 21-7-06. Sane.  
 24-8-06. Sane, works well on typewriter in office.  
 21-9-06. Sane.  
 20-10-06. Sane.  
 1-11-06. Sane.  
 21-12-06. Sane.  
 26-1-07. Sane.  
 18-2-07. Sane.  
 7-3-07. Sane.  
 15-1-08. Sane. Still in asylum.

9. C. S., Syad, Musulman, age 40. Admitted on 25-11-0, by order D. C., Lahore, for observation, and Sessions Judge, Lahore, dated 17-4-05. Delusional insanity (chronic mania).

On enquiry from friends it appears that this man was a qualified Veterinary Assistant—but that from (cause unknown) he, 8 years ago, became insane and lost his appointment, and has been considered so ever since. He had an exacerbation while helping his brother, also a Vet. at Gilgit, five years ago. His divorced wife keeps a Girls' school at Ichra, he induced her on some good pretext to allow him to walk away with a child—this child was found murdered with her jewellery intact shortly after 6-12-02.

No history of insanity or nervous disease obtainable.

PARENTS' CHILDREN. One boy.

CAUSE OF PRESENT INSANITY. Not known; the man himself states that he was addicted to *charas*, but it is not possible to say whether this is correct. He states that he was in the habit of taking 2, 3 and 4 pice worth of *charas* daily for the last four months to procure sleep.

For two years was in the habit of taking half seer of "rum daily."

**DURATION OF PRESENT ATTACK.** 8 years.

**GENERAL APPEARANCE AND MANNER.** Troubled, anxious look. Walk, natural. Paralysis, none. Reflexes, normal. Special senses, natural. Teeth, perfect. Palate, high. Pupils, equal. Reaction, normal and equal. Size, natural. Sleeps badly—dreams—no complaints. Speech on arrival was absurd, incoherent and disconnected, could not give a sensible answer to any questions.

**ATTENTION.** Perfect.

**REACTION TO QUESTIONS.** Answers yesterday were absurd and not to the point, to-day his answers are sensible, understanding perfect.

**MEMORY, RECENT.** Good.

**MEMORY, REMOTE.** Good.

**DELUSION AND HALLUCINATIONS.** That at certain times a multitude of animals of all colours appear before his eyes and he then becomes "behosh"—suffers from palpitation and gives way to any impulse to murder, etc., that may come to him. No taste and smell hallucinations.

**SIGHT AND HEARING** of animals floating about in front of his eyes. Occasionally refuses to obey and becomes very violent.

**Attitude, natural.** Clean, modest, not destructive.

26-11-02. This man on admission yesterday spoke with all the characteristics of a chronic maniac becoming demented. He was put to work and then became obstinate and threatened to attack the attendants. Now, 3 P.M., he is quiet, perfectly sensible, and gives a coherent account of having for years been subject to "attacks," that he has hallucinations of animals with "fear and palpitations" in which state he becomes homicidally impulsive. He gives a most lucid account of another man K. S. of Muzang, having induced him to murder a little girl of nine for the sake of selling her gold ornaments, worth Rs. 30, and dividing this to go to Delhi. He said that the other man committed the murder while he looked on, owns that he was not in a state of excitement at the time.

3-12-02. From the 27th this man has been practically sane. He is however very vindictive and frequently threatens to murder the attendants if they order him to do any work he objects to.

22-12-02. Transferred to stand his trial, "sane at this time." I saw this man on the 10th January, he was then muttering, and restless, difficult to arouse—regardless of those around him and in a very similar condition to that in which he was on admission here.

7-3-03. Re-admitted for purposes of observation by order of Sessions Judge, Lahore. On arrival, morose, but sensible, answered correctly, though in a dull, heavy manner—clean, modest, was wanting in respect.

4-4-03. The whole of the month this man has been perfectly sane, he is now clean, quiet and respectful, and decent. He does what work is required of him, does not object or threaten as was his previous habit. He understands perfectly, answers questions sensibly and intelligently. Has a good memory for answers every time. He states that the sensation of seeing "things" in front of his eyes has now not come on for over two months. He describes this as some "thing," dust or something indecipherable coming before his eyes for a brief period "a

minute or less" but now denies these attacks being followed by "behoshi."

He states that before the murder he had for the first time in his life taken for a month about a *tola* a day of *charas* in a *chillum*. He states that he gave up his occupation as a Veterinary Assistant on account of his "tabiyat," asked in what way—that he had a constant desire to "wander about" and that he had lived since then by begging. His account of the murder which he denies may be false, but it is perfectly sensible. And he is very positive as to his *charas* habit and its duration.

- 19-4-03. Re-admitted, having been found guilty of murder and sentenced to transportation for life by order of the Sessions Judge, Lahore. Sane at time of re-admission.
- 20-5-03. Sane, suffering from fever.
- 2-6-03. Sane.
- 1-7-03. Sane.
- 3-8-03. Sane.
- 20-8-03. Sane, but a scheming liar, very unreliable and lazy.
- 9-9-03. Unaltered.
- 8-10-03. Suffering from ague.
- 10-11-03. Sane.
- 11-12-03. Sane.
- 8-1-04. Sane.
- 11-2-04. Complaining that for the last 8 days "every two days for some half the day" "shaitan things" and nets come before him, with frontal headache. No perceptible mental change. Palpitations at that time—there is a recent swelling over left eyebrow around a small scratch which he states he has done himself after the swelling appeared. The left zygoma is distinctly thicker than right.
- 9-3-04. This man daily complains that for two to four hours each, e.g., yesterday from 12 noon to 4 P.M., and 6 P.M. to 12 midnight he sees numberless "things" like small animals, black, green, and white before his eyes. Left zygoma normal.
- 21-3-04. Always complaining as above. To-day though having no other physical sign except a rapid pulse, he complains of fever and a burning pain in his chest, and requests that he may be shut up alone for a few days, as it will be better, as his health (mental) is not right.
- 26-3-04. Very quiet and reticent. Beginning to be filthy, sits in his excreta and plays with it.
- Speech still very sensible, but is very slow in answering.
- 12-4-04. Now does nothing—but is clean and quiet, no longer complains of his hallucinations.
- 9-5-04. Sensible.
- 3-6-04. Cunning, shrewd, vicious.
- 2-7-04. The same.
- 3-8-04. Cunning, vicious, sane.
- Found with Abdulla and Secander, both attempted to kill him (Secander) behind a barrack.
- 7-9-04. Does nothing except smoke all day—very reticent, becoming very dirty, makes a long wandering explanation.
- 4-10-04. Complains that for the last five days he has been seeing the "shaitan."

- 3-11-04. Complains of being annoyed at night by "shaitan chiz" which makes him feel as though in fever—these he describes as being "like smoke, the smoke of wood" and being very frightful to see—the man does no work, smokes continually.
- 7-12-04. Condition stationary.
- 7-1-05. Sane ?
- 17-2-05. Sane ?
- 29-3-05. Hallucinations of sight by day as well as night—says he sees the devil moving about.
- 26-4-05. As last month. A little work is being done by the man such as plate cleaning.
- 25-5-05. Still much troubled by "spirits" at night.
- 16-6-05. Still much troubled by "spirits," both by day and by night.
- 27-7-05. Still troubled by "shaitan."
- 18-8-05. The devil is now inside him.
- 21-9-05. Very quiet, working well.
- 25-10-05. Quiet, still possessed by spirits, which trouble him very much.
- 22-11-05. No alteration.
- 20-12-05. States that the spirits still bother him; works well.
- 22-1-06. The same.
- 24-2-06. The "shaitans" are still troublesome.
- 21-3-06. As last month, complains that vision is becoming dull; early cataract.
- 19-4-06. Unaltered.
- 24-5-06. Still greatly troubled by "shaitans."
- 18-6-06. No alteration. A man of solitary and retiring habit.
- 20-7-06. No change.
- 24-8-06. Says he sees the shaitans day and night—"they are there"—these "shaitans" talk to him and praise him steadily, never beat him.
- 21-9-06. Retains delusions and is so excessively open in his conversation about them as to lead to an appearance of malingering. Appears to be quite happy in the company of these shaitans.
- 1-11-06. Reiterates same statement.
- 21-12-06. States that day and night the "bhuts" oppress him and torment him, preventing sleep—producing a weight on chest and abdomen.
- 26-1-07. This man daily writes phrases from the Koran in the dust (so that people may trample on it), and writes the same in filth on the floor of his room. He explains this as being to shew his contempt for the Koran which he declares is at the root of all the misery he suffers from the "bhuts" and jins that torment him day and night and make a weight on his chest, etc. It is stated that in his own village he had torn and insulted the Koran.
- Another statement is that, in his village he read and studied the Koran with an Aryan religious teacher who seduced his (C. S.) wife, and that in revenge for this he turned against religion.
- 18-2-07. Complains bitterly of the several hallucinations that worry him at night and what they say to him.
- 7-3-07. The same.
- 15-1-08. The same. Still in asylum.

10. P., Rajput, age 45. Admitted 17-3-03. Class I. Section 302. Melancholia.

This man was charged with killing his own child by striking her on the head with a *lathi* for no ostensible reason. He himself states that he went to beat a cow, and the stick instead of hitting the animal struck his little girl of 7 years and killed her, but he also says that he suffered from complete insanity for nearly a year past, during which time he was obliged to wander about and suffer occasionally from fever and burning feet. Though it is stated that no member of the family was affected with insanity, the mother is said to have died 13 years ago of cough, and his father's elder brother turned Fakir and was thought to be insane.

On admission he appeared a miserable tall man, of unhealthy dark yellow colour, grey, shock-headed hair, and a general look of dejection and misery. He had no abnormality or deformity, but the teeth were discoloured, filthy, distorted, the tongue had black patches both sides, was red and irritable, the palate was high, the conjunctivæ very dark yellow and vascular.

He sleeps badly, complains of constantly seeing, as soon as he falls asleep, "bhuts," devils and dead people, who shake him, awaken him, and frighten him, he has no other hallucinations or delusions, has good memory, understands speech and replies correctly and sensibly though in a whining voice and in a depressed manner. He is clean, modest, not destructive, or suicidal, obeys quietly and at once any order. This man rapidly improved in the next three months, and lost his hallucinations, but he developed a delusion that his children had been seized by the State. In October 1903 he suffered from severe jaundice, on recovery from which, he was found to be perfectly sane, and has remained so to the present day, 27-4-07.

During the summer of 1904 he was tried and acquitted on the grounds of insanity.

11. Case of attempted murder during toxic insanity. Murder.

12. S. S. a Pathan beggar, aged 44 years, admitted. This man strolled into a woman's house, took up her three-year-old son, walked out with him to the well, dropped him in and then took himself to the Police Station; the child was brought up alive from a depth of 18 feet.

It was proved that this man was addicted to drugs; had taken *charas* daily for years, and was notoriously a lunatic, and was in the habit of abusing people, throwing stones down wells, and had a delusion that people extracted his teeth at night. He explained his act by a desire to be hanged. There was no family history of insanity or epilepsy.

In appearance he was a wrinkled, grizzled man with very gruff voice and defective vision. A depressed manner in appearance, with filthy tartar coloured teeth, and ears at right angles to the head.

Speech perfectly natural, his habits clean and modest. He rapidly apparently recovered, and was believed to be sane until it was found that he had a delusion to the effect that an English lady came every night, beat him, ill-treated him, that she had done so for the last twenty years and had knocked out all his front teeth. He has remained unaltered until the present time 30-1-08.

13. Case of mania with homicidal impulses, later becoming demented. Murder.

14. P., son of Hadil, a Hindoo Jat, age 18. Admitted 22-5-04. Class I.

This man murdered a Chumaree with a gundasa, while she was picking cotton in the fields. He was found to be insane when brought for trial, and certified as having paroxysms of violence which increased in the presence of others, but which ceased if he was left alone. While in the intervals he was quiet and morose, paying no attention to anything about

him, usually lying down, becoming however violent and aggressive if in the least interfered with. The boy had no bodily abnormality, except rather prominent ears and very dirty irregular teeth.

He had a curiously restless, shy manner and never spoke of his own accord, and if addressed, either answered not at all or with monosyllables when he could be made to speak; later he professed to know nothing whatever of his crime.

On the 26—04, without any provocation he tried to cut another lunatic's throat, with a kurpa, could or would give no account of his action. A short time before he had made a furious attack on another lunatic. For the next few months it was noticed that he, without warning or provocation, would suddenly murderously attack anyone near him. He could never give any reason for his action.

From December he began to change, "he had suffered a month previously from pneumonia." He was found to be stupid, obeying anybody, filthy in his habits and so deficient in intelligence as to be unable to do any work requiring the least commonsense. Unless called, he would sit without food, while the others ate, though if given it, he devoured it.

On the 17-1-05 he was found unconscious, the condition rapidly passing off, leaving him stupid and dazed as though he had had an epileptic fit. From that date he became progressively more weak-minded, until the present day when he is absolutely demented, but without any of his former tendency to attack those around him.

**15. G. S., Pathan, age 20. Class I. Murder. Shuka Daud. Peshawar. Landowner, Jagirdar. Admitted 29-10-02.**

G. S. attempted to commit murder by shooting a man on 8-8-02, who was driving on the road; he caused a wound. He stated that he did this because he believed the man wished to kill him. Trial deferred as accused was certified as of insane mind.

Is said to be comparatively sane for 2 to 3 weeks and then to become suddenly violent, noisy, to refuse food, and to discard his clothes.

Father died in 1899 after fall from a buggy; one brother was murdered; 7 others alive and sane. No history of insanity in family.

His relations say he has been more or less insane for years. On admission to jail on 12-8-02 behaved in an insubordinate and insolent manner, when being searched. After this his behaviour remained peculiar, he would not answer questions rationally, and seemed to take very little interest in his surroundings. On 3-9-02 he suddenly developed an attack of violent mania, discarded all his clothes, was shouting and dancing about his cell; this continued for 3 to 4 days when he began to quieten down, but his behaviour was never that of a sane man.

On 21-9-02 he again became worse, refused to take his food, was very destructive, refused to speak to anyone, and was extremely morose and as untractable as he was on admission.

A short stout man, dark complexion, Pathan type, prominent eyes, teeth white, perfect.

Denies use of drugs.

Previous attacks of insanity on 3-9-02 and 21-9-03 and on 12-8-02.

SPEECH perfectly natural. Attention perfect, replies quickly and naturally, understands perfectly. Memory, recent, good. Memory, remote, good. Occupies himself here as a durzi, quiet, attitude natural, clean, modest, not destructive.

19-1-03. Still quite sane.

26-1-03. Sane from this date to 2-6-03.

26-9-03. Transferred to Peshawar by order of the Local Government to stand his trial.

10-11-03. Readmitted.

From a Letter of the Magistrate, it appears that this officer believed G. S. to be insane on the day he was brought up, as he refused to answer questions and started about with a "vacant expression;" his trial was therefore postponed.

11-12-03. Sane, troublesome.

8-1-04. Sane.

11-2-04. Sane.

9-3-04. Sane.

18-3-04. Since yesterday, the man has changed, roams about the place with a foolish smile, very difficult to make him speak. Heavy and dull, eating very badly. Sleeping badly. Will no longer work.

21-3-04. Walks constantly up and down the whole day, smiles foolishly at questions, without replying, eating and sleeping badly. Will not work.

12-4-04. Very sullen and heavy, spends most of the day loitering about, with a stupid leer, saying nothing and doing nothing.

9-5-04. Beginning to be sensible again. Has asked for his clothing—expression bright, still is doing nothing.

3-6-04. A little better, but still morose, silent and obstinate, does no work.

2-7-04. More morose—if possible, he stays the whole day in a corner of his room, will do nothing.

4-8-04. Very slow, self-occupied and reticent—always reclining in a corner, will do nothing, very dirty in his habits.

7-9-04. Much improved. Working a little—much more ready to speak.

4-10-04. Has remained sensible.

3-11-04. Practically sane.

7-12-04. Sane.

7-1-05. Sane.

14-2-05. Removed to Peshawar to stand his trial. Has since visited the asylum—has been acquitted by the Court.

16. B., a Mahomedan, age 40. Admitted 24-8-04. Acquitted on grounds of Insanity. Murder.

#### EPILEPTIC INSANITY.—

He came to his home after a fit while in a state of "behosh"—his mother caught hold of him to prevent him leaving—he resisted and in dragging her along her head struck against the door fracturing her skull. One cousin suffered also from epilepsy. No "insanity" in family. Barz is said to have suffered from epilepsy since 1898.

This man has constant epileptic fits of an ordinary type, usually in a series of several in one day. Though in the intervals he is fairly quiet, dull and rather stupid, before the onset he is very morose, inclined to grumble and declaim on points that cannot be understood, and is then and afterwards most dangerous, violently attacking anyone who approaches him. After the fits it is the same, except that he then becomes violently excited, shouts, declaims, rages up and down his room and is also then most dangerously homicidal.

17. B., a Kumhar, age 45. Admitted 24-2-05. Recurrent mania. Unable to plead (being insane). Section 304. Killed his own daughter—he gives a plausible story of his brother having accused him falsely, and that the child was really crushed between two bullocks.

His father was insane. One brother has been twice imprisoned for theft.



**CERTIFICATE.** "Cries for no reason, has spells of melancholy, when reference is made to the death of the girl he is stated to have killed—he cries bitterly and says he loved the child."

This man for a long period in the asylum was simply morose, sullen, silent, refusing to work—angry and irritable—then he suddenly altered and for a few weeks was excitedly abusive, noisy and excited—these attacks occurred at irregular intervals—and in the interval he was as before, but began to have delusions that his daughter was alive, etc., he was always obstinate, violent, if spoken to on the subject of working, and very unreasonable—in March this year 1907 he had another attack of acute mania attended with much aggressive violence, and is now again fairly quiet and more reasonable than he has ever been.

30-1-08. Since this was written he has again become morose and aggressive and announces his intention of killing 2 particular men at the first opportunity.

**18. S., a Brahmin, age 30. Admitted 25-11-04. Toxic insanity. Section 307. Unable to plead.** Charged with having pushed "Chagee" into a well, the latter bending over to draw water; accused who appeared to have been annoyed at having been refused *charas* is said to have pushed him in. Chagee was rescued.

Accused was found to be of "unsound mind owing to excessive use of *charas*;" when in Court he paid no attention, and when asked for an explanation, said, he had thrown a man into a well, but that it was not Chagee; again "he said that Chagee fell in, and later that no one fell in at all;" he seemed unable to concentrate his mind on any subject for a moment at a time, and was therefore remanded.

He has remained in the asylum up to the present time in the condition of chronic mania, in which he was when first admitted.

**19. F., a Rajput, age 32. Admitted 11-6-04. Class III Section 302. Sentenced on 9-8-98 to transportation for life for murder. No particulars of crime.**

Delusional insanity (chronic systematized.) No previous history whatever.

This man, though paralysed in lower limbs as a result of a fall from a tree, is most dangerous—always assaulting some one with the stick he carries to assist him in moving. He has a coherent delusion that the Superintendent and Daroga of the jail have put magic upon him and incite others to annoy him—of late this has been varied to the extent that the Superintendent put the "fat of dead men" in his food—as a consequence he is always making murderous assaults on people, and is most foully abusive.

He seems to have no hallucinations and can talk sensibly if he will only keep away from the subject of his delusion.

He remains unaltered up to date May 1907.

**20. S. D., age 39. Admitted 11-6-04. Sentenced to transportation for life on 21-10-01, for murdering his wife whom he suspected of unchastity. Chronic mania.**

This man's mother died insane.

This man is now and appears to have become gradually after his sentence—while in jail, a chattering, foolish, unreasonable chronic maniac, with wandering foolish speech—subject to fits of excitement and anger over trifles—always ready to talk—of late he has become more fatuous and silly, and his recent memory is rapidly deteriorating, but otherwise he does not alter and is still in the asylum.

**21. J. D., a Mahomedan, age 26. Admitted 19-7-04. Trial postponed, he being insane and unable to plead. Melancholia. "On 30-5-04**

J. D. visited the takias of one Saidullah Khan, met among others Umara, there he had a smoke of *charas*, went with Umara to wash his feet in a stream close by, Umara had a chopper with him, an altercation ensued, J. D. seizing the chopper killed him by striking him repeatedly on head."

Father said to have been insane.

**CERTIFICATE.** "Is very filthy in habits, tears away clothes and remains naked, is indecent, sometimes sullies his person with filth, breaks vessels in which food or water is supplied to him, digs earth from his cell. Does not answer questions."

**APPEARANCES, etc.** A stolid looking, pale-faced young man, who stands still, replies by signs and will not speak. Very well nourished—ears, a little prominent, head and body, naturally shaped—refuses all food. Clean habits—always mute, stolid, indifferent.

Beyond occasionally speaking a little and taking on filthy habits, he did not alter for the next 4 months, but was noticed to be very irritable and often aggressive, and on 13-12-04 he strolled up to another lunatic whom he found sleeping in his (J. D., accused's) corner of the garden, and before he could be prevented, killed the man by stamping on his body (breaking several ribs, rupturing spleen and liver) with his naked foot—J. D. seemed quite unconcerned when accused and simply shook his head and pointed to the sky.

After that he remained for a year silent, filthy, usually crouching against a wall, but in the beginning of 1906 began to improve and by the end of that year was absolutely sane—and is now a clean, well-behaved man—he persistently denies having any recollection of the murders.

**22. W. S. Jat Sikh, age 25 (?).** Recurrent melancholia. Originally admitted on 25-8-99.

This man committed murder of (?) in May 1899, as he states when temporarily "behosh" as a result of Indian hemp, and that he remembers nothing of the crime. While under observation in jail he shewed signs of melancholia, and remained so until 31-10-00 when he suddenly changed, bewailed his crime, refused his food, etc., stating that he was a wicked man and having committed murder must die for it. Circulation was noticed to be very defective and extremities blue. From 1-4-01, he commenced to improve and remained sane except for slight foolishness of manner until his discharge in June 1902 to stand his trial. It is worthy of note that he had typhoid in the Asylum in March 1900 but made apparently a perfect recovery.

No insanity in family—a particularly natural good-looking Sikh. He was acquitted on ground of insanity and re-admitted 7-3-03, sane, remaining so until 27-3-03 when he suddenly changed—speaking foolishly, though coherently, maintaining one fixed attitude, etc. During the next two months became occasionally excited and was unable to work, he had before been a most useful nurse in the Hospital. By April 1903 he was again sensible and sane a month later and has remained so to the present time, January 1908.

**23. Q., age 30.** Admitted 5-12-91. Section 302. Chronic melancholia.

Sentenced to transportation for life on 18-6-90 for murdering with a toka a lad who was supposed to have an intrigue with his sister.

Became melancholic in jail. In Asylum morose, silent, refusing to work,—liable to fits of most dangerous excitement when spoken to. Glares at passers-by, wanders about all day doing nothing. Speech sensible. Later developed delusions that he was nightly strangled to death by one of the keepers, but was brought to life again by virtue of a faqir each morning.

Then followed a slight attack of hemiplegia. Most dangerous in his efforts to avenge his supposed persecutors.

• He remained practically in this condition until his death from chronic dysentery, 26-12-06.

**24.** K. Class I, Section 302. Admitted when 40, on 17-1-03. Toxic insanity.

Killed a man without the slightest provocation. Since admission, defective memory, rambling speech, delusions of Devtas and drunken women coming to eat from him at night and to annoy him. He remained in this condition of chronic mania, harmless and foolish, very loquacious, but always suffering from auditory hallucinations and occasional fits of irritability until his death on 8-4-07. of meningitis following pneumonia.

**25.** M. S. T., age 30. Admitted 30-8-03. Class I. Section 302. Chronic melancholia.

This woman killed her own little child and kept the body on her lap for 3 days until discovered. She has always been in the Asylum in a condition of melancholia, weeping and bewailing, with delusions of her husband and 4 sons being confined close by, quite unreasonable.

30-4-07. Still in the same condition and in the Asylum.

**26.** F., age 20. Admitted 30-9-04. Section 302. Melancholia.

No particulars of crime. This man for years remained silent, obstinate, depressed, and cataleptic, occasionally becoming incoherent and talking violently, on one of these occasions he assaulted another patient without any provocation. He died of pulmonary tubercle, 22-6-01.

**27.** M., age 40. Admitted 6-8-91. Class II. Section 302. Killed a man striking him with a *lathi* on the head. No other particulars.

Quiet chronic maniac, formerly addicted to *bhang* and *charas*. Suffered from chronic asthma, died suddenly, heart failure, 26-12-02.

**28.** J. B. C., age 45. A Native Christian. Admitted 21-7-92 Class III. Culpable Homicide. Sentenced to transportation for life, 3-3-82.

This man murdered his wife. No particulars. He is now a quiet, chronic maniac. Full of delusions that he is a physician, that he is Superintendent of the Lahore Central Jail and a resident of Abyssinia, talks foolishly and dresses fantastically. At first he was excitable and easily roused, but now he has become quiet and harmless, and happy, and is still in the Asylum. He is given to covering sheets of paper with unmeaning characters.

**29.** K. M. Class III. Culpable Homicide. Sentenced to transportation for life.

No particulars of crime. An epileptic, usually having one attack a month, before which he is extremely talkative and excitable. In the intervals he is quiet, sensible, though always incapable of appreciating his crime or the justice of his imprisonment.

**30.** S. B. K. age 48. Admitted 2-3-97. Sentenced to transportation for life. No particulars of crime.

Admitted originally for mania from which he recovered completely, except that he had a tendency to become easily excited. He remained sane and died on 1-2-02 of pneumonia.

**31.** C., age 39. Class II. Admitted 23-11-93. Melancholia.

Attempted murder. This man gives a consistent account of having fought and wounded another man while in a state of intoxication. At first

used to remain in one attitude refusing to answer but repeating "Ram, Ram." Later he improved, became very sensible, with good memory, but peculiar habits, for instance, coming up quietly and suddenly shouting out some foolish remark, then going away at once quietly. Sometimes he talks perfectly sensibly, at others was foolish. He remained in this condition becoming very fat, cheerful, self-satisfied until May 1906, when after recovering from an injury to his foot, he rapidly became sane and has remained so to the present day.

**32.** P. D., age 35. Admitted 18-2-94. Melancholia. Section 302.

This man killed his wife. In the Asylum he was at first melancholic, but later recovered; though he always remained liable to fits of great irritability. He had good memory, never showed any remorse for his crime, later he became weak-minded, foolish. For the last 5 years he has been discontented, absolutely devoid of any moral sense, but otherwise extremely sensible and intelligent.

**33.** A. K., age 24. Admitted 2-3-94. Class II. Section 302. For Mania.

This man denies all knowledge of the murder of which he is guilty. He is subject at varying intervals to attacks of acute excitement in which he is most violent and dangerous and murderously aggressive.

These attacks come on in the course of a few hours and last some two to three weeks. When in this state his great desire seems to be to make a sudden murderous onslaught on everyone near him, and frequently does this when apparently sensible and quiet.

Between these attacks he is absolutely sane, this interval usually lasting sometimes 20 months, sometimes only 4 or 5. He is still in the Asylum 30-1-08.

**34.** H., age 60. Admitted 23-12-94. Section 302. Mania.

This man killed his wife, and insists that he had a right to do so, that his detention was therefore unlawful. It appears that he was working in the fields though deemed to be an occasional lunatic, that his wife took him out his dinner and he (H.) was seen a little later bending over her body pulling out her intestines, having killed her with a sickle. He soon recovered remaining only somewhat irritable and unreasonable and easily excited, later he became more sensible and has for the last 4 years been practically sane.

**35.** L. B., age 36. Admitted 8-2-96. For Chronic Mania. Section 302.

This man murdered his sister-in-law. No particulars. He has been continually aggressive, excited, angry, with incoherent speech. Has remained practically in same condition, violent, angry, self-occupied, obstinate and irritable until the present day.

**36.** P. S., age 22. Admitted 28-7-96. Section 302. Toxic Insanity.

This man murdered his wife in a fit of mania from *bhang*. In Asylum has been extremely quiet and well behaved. Abnormally shy, timid and nervous, speaking and working sensibly till the present day, 1-5-07.

**37.** A. admitted 12-8-91 at age 40. Murdered a little girl with a stick.

Melancholia in Jail, but quickly recovered in Asylum and shewing no sign of insanity, was on 28-7-00 retransferred to Jail.

**38.** Msr. G. Sections 303 and 304. Admitted 27-5-99.

Sentenced originally to one year's R. I. for helping to conceal the body of a dead child. Being in a state of mania, on appeal was acquitted on ground of insanity.

Recovered and discharged on security 1-1-02.

**39. W. Admitted 10-6-99. Section 302.**

An epileptic who murdered his own child; unable to plead by reason of insanity.

Died of chronic dysentery 5-12-00.

**40. B. D. Admitted 27-6-99. Section 302.**

Acquitted on ground of insanity. Having thrown a man of 80 into a well in a state of mania after having beaten him most brutally with a stick. No provocation whatsoever. Recovered. Transferred to Central Jail 21-6-06.

**41. S. M. Admitted 10-11-99. Section 302. Class I. Was unable to plead.**

This man murdered three others without provocation; he himself professes to know nothing about it. A case of mania with violently aggressive impulses, who later became very dull and stupid. Still in Asylum.

**42. K. 30-12-99. Acquitted on ground of insanity. Section 302.**

Murdered his wife, professes to know nothing about it. A case of melancholia. Died in Asylum on 15-5-02.

**43. F. Admitted 31-12-99. Section 307.**

Became insane while undergoing 7 years' transportation under Section 307. A case of mania, rapidly recovered. Discharged sane, 5-7-02.

**44. T. M. Admitted 16-10-97. Section 302. Acquitted on ground of insanity.**

Killed a man with a blow from an axe, no other details. Denies all knowledge of his crime. A melancholic with delusions of being unable to eat; recovered, but in 1903 had an attack of mania (?) marked with a general rage of violence. Recovered and died in 1905 of gall stones and pyelophlebitis.

**45. I. K. 16-10-99. Acquitted on ground of insanity.**

Killed his half-brother, suddenly cut his throat in a field where they were ploughing, used to give a clear account of it and argue that he did rightly. Delusions of being a Badshah. A chronic maniac, usually quiet but most violent and dangerous if in the least irritated. Died of phthisis 28-8-06.

**46. E. 2-3-98. Acquitted on ground of insanity.**

No particulars of the murder he committed. A chronic maniac who died of tubercle 20-5-00.

**47. A. D. 4-10-98.**

Sentenced to 5 years' R. I. on 25-11-95 for culpable homicide and grievous hurt. No other particulars of crime. A melancholic. Discharged on security 16-11-01.

**48. F. Admitted 5-11-98. This man was in prison undergoing sentence for a murder, being an epileptic with apparently no memory, was an unknown vagrant. Died suddenly in a fit 25-8-00.**

49. S. 25-11-98. Kept until able to make his defence.

A case of toxic insanity, confined here for having smashed his wife's head with a millstone. Had no memory of the act; states that he was then in a state of 'Nasha,' knew nothing of what he did then, his wife was a good woman and that he had no desire to kill her.

50. M. S. or D. S. 28-2-99. Unable to plead (being insane).

Suddenly killed another lunatic with a hoe (absolutely no provocation) while under treatment as an ordinary lunatic. This man had turned faqir because he was refused enlistment. A chronic maniac.

51. M. 30-4-99. Acquitted on ground of insanity. Section 302.

Killed his wife as he states while under the influence of intoxicants, he had no memory of doing so nor for 2½ months afterwards. Toxic insanity. Complete recovery. Died 12-6-00.

52. J. 19-11-89. Kept until able to make his defence. Section 302.

Murdered his own son. No details. An irritable incoherent chronic maniac, never alters. Still in the Asylum, 1907. Very ready to beat his fellow-patients.

53. J. 17-4-84. Acquitted on ground of insanity. Section 30.

Murdered his wife, no other details. Was admitted in a state of acute mania. Became demented. Died 14-5-02.

54. N. M. 2-11-84. Section 302. Unable to plead.

Murdered a boy. No details.

A chronic maniac now demented and still in Asylum 1907.

55. A. H. 3-6-92. Section 302. Class I. Unable to plead.

Committed murder by running amock in Delhi city. A chronic maniac. Still in the Asylum.

56. A. 27-9-82. Section 304. Unable to plead.

Murder. No details. A chronic maniac now demented and in Asylum 1907.

57. A. K. 3-5-84. Section 302. Acquitted on ground of insanity.

Was in Central India Horse and in Bhawalpur army; turned out of both for "tumultuous conduct." On return home after acting strangely, suddenly cut his son's (a child of 2) throat with a small pocket knife—in consequence as he said of a dream. Chronic Maniac. Died 22-9-01.

58. S. 20-4-77. Acquitted on ground of insanity. Section 302.

Broke his wife's skull with repeated blows from a large stone. Had been previously insane since age of 10. Chronic maniac (Toxic). Still in Asylum.

59. Q. 6-10-06. Class I. Section 302. Unable to plead.

Murdered his wife. A man from the same village states that Q. (who had notoriously been from time to time insane) was cutting fodder with a gundasa—he called one of his two wives up to him, and without a word cut her head completely off.

Admitted in a condition of resistant melancholia—in which he remained for some time, but early in 1907 recovered; no memory of his murder.

**60. A. G. K. 25-10-06. Section 307. Acquitted on ground of insanity.**

A case of paranoia, who believed that the Sikhs had formed a conspiracy to persecute him (he was a Jemadar of the Hong Kong Military Police and had come on leave to the Punjab) in consequence of which he went to the D. C. demanding protection, was allowed to stay for that purpose for the night in the thana and then tried to shoot a policeman there with his revolver. Died in Asylum of suppurative perinephritis.

**61. A. 1-12-06. Section 302. Class III.**

Originally sentenced for murder (no particulars), but acquitted on appeal on ground of insanity. This man suffered from melancholia but has a constant habit of suddenly making homicidal assaults on people for no apparent reason whatsoever.

**62. K. 3-12-06. Section 302. Acquitted on ground of insanity.**

This was a case of melancholia, the man had been suffering for a year in his own home, unable to work, had visited various places and people for treatment; he quite suddenly on 18-6-06 got up and killed his two little girls with an axe, and attempted to do so to another who survived. He was at once caught (the murder was seen) and began weeping—saying that the whole thing was due to fate, etc., and begged to be allowed to help place the children on a bed, etc. Rapidly recovered under treatment, and is now sane, a simple, hard-working, well-behaved man, 30-1-06.

**63. S. A. 13-7-05. Class III. Sections 304 and 334.**

Found to be an epileptic while undergoing 4 years' imprisonment for Section 304. No particulars, an epileptic insane of aggressive tendencies. Still in Asylum.

**64. Msr. K. admitted when 20? on 14-5-06 for melancholia.** A woman who became insane in Jail, undergoing sentence for having thrown her own child into a canal—was for 7 months in a state of melancholic stupor, gradually recovered by middle of 1900 and becoming perfectly sane, was retransferred to Jail 22-5-02.

**65. M. B. Admitted 2-9-96. Chronic mania, aged 55.** An old Mahomedan regarded in Lahore as a Pir, who suddenly without warning got up and stabbed a young man near him.

A chronic maniac with delusions of sight, hearing and touch that people came through his cell wall at night and annoyed him, that he controlled a "Jin" who would do anything he asked, &c.

Later he became demented and died of pneumonia on 17-12-04. Class I, unable to plead.

**66. N. Class III. Section 302, aged. Admitted 12-10-96.**

Stated that he murdered his wife during opium intoxication. A chronic melancholic with delusions of everybody being against him. Still in Asylum 1907. Became insane in Jail while undergoing transportation for life—originally sentenced to death.

**67. A. A. 13-1-97. Class I. Unable to plead.**

Murdered his wife—always states that he did so of his own *kushi*. A chronic maniac, always naked, incoherent and exalted. Still in Asylum, 1907.

68. D. D. aged 55. 23-1-97. Acquitted on ground of insanity.

Killed a boy with a club and attempted to kill three others, no obvious provocation. Formerly an opium eater taking 23 grains daily. This man is still in the Asylum. Beyond being querulous and rather unreasonable he seems sane, and apparently committed his murder while intoxicated.

69. P. S. 12-6-96. Acquitted on ground of insanity.

Murdered his brother. No memory of the act. It appears this man suddenly ceased cutting corn in a field and strangled his brother who was near him. He was then believed to suffer from periodic attacks of *petit mal*, but these were never observed in the Asylum where he was regarded as a melancholic. Died in 1906 of pulmonary phthisis.

70. N. H. 25-3-97. Class III.

Became insane while undergoing 7 years' rigorous imprisonment for murder. (No particulars). Sentence dated 5-12-96. A chronic maniac with constant impulses to homicidal violence, most dangerous, spent his whole time in attempting murder.

71. A. 10-8-99. Acquitted on ground of insanity.

Killed his paramour; no other particulars. Denies all knowledge of his offence. Still in Asylum 1908. Subject at short intervals to recurrent mania, the intervals between which are becoming shorter and the duration of each attack longer. In these he wishes to convert the Prince of Wales and all Europeans to Mahomedanism and has a curious habit of leering and speaking, mimicking a falsetto voice.

72. I. D. 26-8-97. Unable to plead. Section 302.

A melancholic with delusions that his family were starving—in consequence of which he threw his infant son into a well. Second attack of insanity. Attempted suicide twice in the Asylum. Subsequently recovered. Left to stand his trial 9-7-02; was acquitted.

73. J. 14-3-78. Class III.

Became insane while undergoing sentence in Jail of transportation for life for attempted murder. A demented chronic maniac. Died 10-1-03. Tubercle.

74. R. C. 1-1-81. Section 304. Unable to make defence.

No details of his crime, homicide. A chronic maniac. Died 7-12-05. Pneumonia.

75. M. 23-4-81. Section 302.

Sentenced to transportation for life for murder. Found insane in Jail. A miserable old man with delusions of people nightly throwing fire on his head. Died in Asylum 22-3-03. Tubercle.

76. J. 21-4-81. Section 302. Acquitted on ground of insanity.

Killed his own sister, no details. A chronic maniac. One night was locked up with another lunatic—and in the morning it was found that J. had killed him and had partially eaten him. Always talking incoherently about killing something, was originally a butcher. Died in Asylum 13-3-07.

77. M. 7-10-81. Section 302. Incapable of making his defence.

Murder. No details. Still in Asylum. A chronic maniac who became demented.



**78. M. 18-10-90. Section 302.**

Sentenced to transportation for life 17-7-88. Murdered his wife; no details. Suffered from recurrent attacks of acute mania. Died 19-8-01.

**79. N. A. 16-2-89. Section 302. Class I, i.e., unable to make defence.**

Killed his brother, no details. A melancholic who rapidly became completely demented. Died in Asylum 1907.

**80. Msr. M. Class III. Section 302.**

Murdered a child of three who in following a goat came into her house. It was said she did so as revenge for her being refused in marriage to her (M.'s) little son.

Sentenced to transportation for life, became melancholic in Jail. Recovered, retransferred to Jail.

**81. A. M., 16-4-00. Section 302. Acquitted on ground of insanity.**

Murdered his son and wife, and attempted to murder his daughter in an ungovernable fit of rage—to attacks of which he was subject. Always unreasonable, exalted and restless. Having slightly improved was allowed to be transferred to Andamans at his own request.

**82. F. 4-1-00. Acquitted on ground of insanity. Sections 302 and 326.**

Killed a boy with an axe, no other particulars. A case of acute mania, rapidly recovering. Transferred to Jail 21-6-06.

**83. S. S. 14-2-00. Section 307. Unable to plead.**

This man who for 22 years had been addicted to *Charas*, spirits and opium—in a state of "Nasha" threw a boy of 5 down a well. Ultimately recovered, is now in Asylum 1908.

**84. Msr. D. 25-7-97. Acquitted on ground of insanity.**

Killed her child by throwing it on the ground when in a state of melancholia—noticed in Asylum to be very cruel to children. Has not recovered.

**85. B. 14-2-00. Acquitted on ground of insanity.**

Killed his own daughter by throwing her into a well while in, as he stated, a condition of "Nasha," produced by a pill given by a faqir. Generally in a condition of mania (Toxic). Died in Asylum of dysentery 8-1-02.

**86. J. 22-7-05. Section 302. Class I. Unable to plead.**

Killed his mother with a gundasa because she did not cook his food properly—was at that time suffering from melancholia (father was insane). Rapidly recovered, removed to stand trial 20-7-06, but immediately he became again insane. Now in Asylum 1907.

**87. G. S. 3-10-05. Section 302. Acquitted on ground of insanity.**

Seen to drop a stone of 35 pounds weight on the head of a woman who had been sitting beside him under a tree. The woman died and the man was arrested by the constable who saw the act.

It was proved that he had had periodic attacks of mania for 7 to 8 years. At trial had no recollection of his crime. At the time of murder he had been "chained" and escaped. Admitted to Asylum in state of melancholia, still in that condition 1908.

**88. B. S. 17-10-05. Section 304. Acquitted on ground of insanity.**

"Accused (an old man of 80) who had not been in his proper senses" for a year, attacked and killed his step-grandson, aged 2, with a club. The boy had come after him with a handful of cooked rice, the grandmother tried to help the boy and was also attacked. Accused's condition followed "fever." No memory of crime or of his trial or of leaving his village. Died in Asylum 16-10-06.

**89. M. R. 21-3-06. Section 302. Unable to stand trial by reason of insanity.**

An epileptic charged with murder, no details. A most dangerous man, always liable to make sudden violent assaults without provocation. Still in Asylum.

**90. A. 24-6-05. Section 324. Class I. Unable to plead. Age 40 (?).**

"Caused grievous hurt to another person," i.e., attacked without provocation another man who was at work, beating him severely with a stick and fracturing his skull.

• Suffering from mania, still in Asylum and in same condition.

**91. B. 23-12-06. Section 302. Acquitted on ground of insanity.**

Arrested originally as being a simple lunatic, allowed to be taken away by his friends. Insanity had come on suddenly, August 1906.

Four days after return home murdered his pregnant wife in a most brutal manner with a hatchet ripping open her abdomen. No clear recollection of murder. Father, uncle and grandfather all had been insane. Has now completely recovered from his attacks of melancholia.

**92. A. 31-3-06. Section 302. Acquitted on ground of insanity.** On night of 11-11-05, A, who had become maniacal two months before and had been shut up by his relatives escaped from their custody, met a chamar near his door and stabbed him twice in the back and stomach with a spear head, killing him. Sane on arrival at Asylum. Still so, 1907.

**93. R. C., aged 20. 22-5-06. Section 302.**

Occasionally had attacks of simple mania, in one of these he was tied down (by his aunt and mother) to a charpoy—he escaped in the night—went to his aunt—on her attempting to quiet him he struck her twice on the head with a *lathi*, and then trampled on her body, saying she was possessed with an evil spirit.

Father an epileptic. Mother regarded as not sane. Several attacks of acute mania in the Asylum.

**94. A. K. 2-6-06. Section 302. Acquitted on ground of insanity.**

A sepoy in Burmah Police admitted into Rangoon Asylum in 1899 having, while insane from indulgence in *Gunja*, when on sentry duty, shot his Naick and murdered another sepoy.

**95. G. 4-7-06. Section 302. Unable to plead.**

Murdered his father without any obvious cause—"was always to an extent weak-minded" and was thought to be "insane by his friends." Admitted as a melancholic. Still in Asylum 1907.

**96. F. 15-7-05. Section 302. Class III.**

He without any motive murdered his sister in her house, and another man in the street with a hatchet, fled away and was arrested with blood stained clothes and hatchet two miles away. "Generally considered as an insane." Tried and sentenced to death. Sentence commuted to transportation for life. Found to be insane while awaiting sentence. Has been in a condition of melancholic stupor ever since admission up to May 1907. In autumn 1907 gradually improved and is now slowly recovering.

**97. I. B. 19-9-05. Section 302. Class III.**

This man was associated with a number of *budmashes* in Multan City, and on 8-10-98, when only 18 years old, either murdered or abetted in the murder of his father with whom he had had various quarrels, and was therefore sentenced to 14 years' rigorous imprisonment. Found to be melancholic in Jail.

Admitted, recovering but morally deficient, always ill-treating the other patients. Never speaks unless addressed. During January 1908 suddenly attacked another lunatic with his platter. No obvious provocation.

**98. M. S. 16-11-05. Section 302. Class III.**

Sentenced to death for having murdered his second cousin with whose wife he had an intrigue—body had been strangled and thrown down a well.

Sentence commuted to transportation for life. No details of commencement of insanity—not sane at trial. Admitted in a condition of acute mania. Recovered, February 1907.

**99. H. 21-3-1906. Section 302. Class III.**

Convicted of murder—had a fight with one Tuls about a woman—killed T. by cutting off his head with a dhatra. An epileptic maniac, who rather delights in giving an account of his crime—said to have delusions of being a god, etc., but none noticed in the Asylum.

Sentenced to imprisonment for life—beoming demented, constant epilepsy.

**100. B. S. 17-11-06. Section 302.**

Sentenced to death by Sessions Judge. On appeal to Chief Court acquitted on ground of insanity. Denies all knowledge of the murder. He murdered a sleeping Chamar at night without notice—"Splintered his face to fragments"—was believed by others to be insane at that time but he certainly ran away and tried to escape the consequences. It appears that the man was suffering from melancholia following after an acute illness. Now sane. Persistently denies all recollection of his crime, 30-1-08. A quiet, respectful, most well-behaved man.

**101. C. 7-4-00. Section 304. Class III.**

Found insane while undergoing four years' imprisonment under Section 304. No record of crime.

Subject in Asylum and Jail to attacks of recurrent mania of a most violent description, but remaining sane all 1902 and 1903 was discharged, November 1903, on security.

**102. S. A. 5-5-00. Section 302.**

No record of murder for which he was undergoing seven years' imprisonment when found to be insane—noticed to have a habit of suddenly attacking others without obvious cause, found to be a paranoiac with delusion of an enemy and auditory hallucinations. Died of phthisis 8-8-00.

**103. K. 6-5-00. Section 302. Acquitted on ground of insanity.**

While insane through "grief" at absence of husband killed her two children aged 3 years and 3 months, respectively, by cutting their abdomen open with a rambi.

Admitted with melancholia from which she subsequently recovered; still in Asylum and sane; very rough and even cruel with other women; dull and stupid.

**104. R. 24-4-00. Section 302. Class III.**

Became insane while undergoing 7 years' imprisonment under Sections 302 and 307 having murdered a child, and attempted to murder a woman. Admitted in a condition of most violently acute mania. Recovered September 1900, and remained sane to 12-12-05, when he was transferred to jail.

**105. P. 28-6-00. Section 302. Class III.**

A man of notoriously bad character, addicted to opium, *bhang*, *charas*, and spirits—no ostensible means of living—previously placed on security for good behaviour. On night of 20-1-98 suffocated his wife with his turban while she was asleep, and in morning himself reported matter to police. Alleged cause of murder was a quarrel with his wife as to whom daughter should be betrothed to. Believed sane, sentenced to transportation for life. While on journey he certainly obtained possession of a large amount of *charas*, and was found to have suddenly become insane (mania). Admitted in a stuporose condition. Later became foolish and exalted and gradually became sane in 1906.

**106. K. 3-7-00. Section 302. Acquitted on ground of insanity.**

Murdered his own mother. No details. After trial passed into a condition of melancholic stupor. Died 13-11-00. Phthisis.

**107. K. 16-7-00.**

Shot his wife with a pistol, tried, acquitted on ground of its being an accident but sentenced to six months' imprisonment for being in possession of arms. Coincidentally with trial became insane, melancholic, rapidly passing into condition of melancholic stupor, remained in that state and removed by friends 20-8-00.

**108. A. H. 21-7-00. Section 302. Incapable of making defence, and later acquitted on ground of insanity.**

Murdered a little girl by hitting her with a mobli as he stated immediately afterwards in revenge for the mother having abused him, had been formerly sentenced in 1895 to one year's imprisonment under Section 326. "Always regarded as a quarrelsome lunatic." Admitted in condition of melancholic stupor, recovered later sufficiently to stand trial. Still in Asylum and sane.

**109. Mst. F. 7-8-00. Section 302. Acquitted on ground of insanity.**

In April 1897 threw her little girl of 2 into well, was seen to do so—explained her act by saying that the child had gone to meet a relative of the

district—she was quite incoherent. It appeared that her insanity was a result of grief at the death of her third child, a boy, of whom she was very fond.

Admitted in a condition of chronic mania, liable to exacerbations of violence, etc. Still in Asylum.

**110. L. 22-10-00. Section 302. Class I. Unable to plead.**

Murdered his own father by fracturing his skull with a brass hookah, in a temple to which the father had taken the son in order that he might be cured of his insanity from which he had been affected for 2 years—this latter is said to have followed "paralysis" (slight, left hemiplegia).

Admitted in condition of melancholia. Died 14-1-01 of ruptured spleen after a quarrel with another lunatic.

**111. N. 26-11-00. Section 302. Acquitted on ground of insanity.**

Murdered an old man by smashing his head in, remained by the body afterwards with the stick by which he had effected it in his hands, "made no attempt at escape, gave only an incoherent answer." Father had also been insane.

Admitted in a state of stupor after mania. Recovered and has remained sane up to present time. No memory of his crime.

**112. M. 10-12-00. Section 304. Class III.**

Found insane while undergoing four years' imprisonment for Section 304. No details. Found to be an epileptic insane, of most dangerous character, always attempting assault.

**113. S. H. 24-12-00. Section 302. Class I. Incapable of making defence.**

Murdered his mother, no details. An uncle said to have died insane.

Admitted with melancholia. Died in Asylum 1-5-04.

**114. S. S. 12-1-01. Section 307. Acquitted on ground of insanity.**

No history of his crime. A case of chronic mania, always violent and unruly. Still in Asylum and quite unaltered.

**115. W. R. 19-1-01. Class III. Culpable homicide.**

Became insane in Jail while undergoing transportation for life for culpable homicide. He appeared to have had an attack of mania following "fever" and to have killed a man with a knife. Sane in Asylum. Transferred to Jail 1905. Subsequently released 1906. Sane.

**116. G. M. 7-1-01. Acquitted on ground of insanity. Section 302.**

Murdered his kitmatgar in a fit of passion. A case of toxic insanity. Died of heat apoplexy 13-6-01.

**117. K. 19-1-01. Section 302. Acquitted on ground of insanity.**

Confesses to having murdered a woman in the street with a piece of wood lying by—had indulged to excess in *bhang* and *charas*; on this day he had taken a tola. Toxic insanity. Sane in Asylum. Transferred to Jail 23-7-06.

**118. K. D. 19-1-01. Section 302. Class III.**

Said to have murdered a woman in the heat of passion; for this was sentenced to transportation for life. During this he was found to be insane. Admitted as a chronic melancholic. Still in Asylum.

**119. B. 19-1-01. Section 302. This man in a state of "behosh" from bhang threw his sister's daughter of 1½ from the roof of the house to the ground, causing her death; he owned to have taken a large quantity of bhang that day.**

Toxic insanity. Sane on 6-4-03, when he absolutely suddenly became acutely maniacal; by November he was again sane, and has remained so to the present time, he had undoubtedly obtained possession of some Indian hemp on the previous occasion.

**120. K. 19-1-01. Section 302. Class II. Killed a woman who had incited his wife to immorality in a fit of rage—confessed—sentenced to transportation for life. A feeble old man at trial and in bad health all the time of his imprisonment; later became insane.**

Senile mania. Died in Asylum, 27-5-01.

**121. S. 17-3-01. Section 302. Class III. Found insane in Jail while undergoing sentence of 10 years, Section 302. No details. A case of melancholia, died 3-9-01.**

**122. T. 1-5-01. Section 304. Acquitted on ground of insanity. A man addicted to charas in excess, for which habit he was obliged to leave his regiment—because his wife refused him money for charas, he deliberately shot at her. He later recovered—and his discharge on security was permitted by the Local Government.**

The history is that in this fit of rage he shot at his wife, but instead, missing her, the bullet struck his mother-in-law. From the evidence he was acquitted on the ground of insanity. This man, ever since arrival, had been always the same; quiet, self-contained, clean, orderly and intelligent, a good worker, without delusions, and indeed without any of the usual signs of insanity. He was, however, if once made angry (and he became so from trivialities, which did not affect others), absolutely ungovernable, quickly became violently angry, and in his rage would commit murder without the smallest effort at self-control. On one occasion he differed in opinion with another lunatic in the tailor's shop, as to which way the sewing cotton should be rolled; instantly he flew into a violent passion, and was with only the greatest difficulty prevented from murdering the other with a brick. He was, when quiet again, aware of his failing, though unable to control it, and on this occasion came up himself to the Superintendent to beg that the occurrence might not be entered against him. This, it may be added, he did not from any sense of shame, for it is noticeable that he was quite devoid of any regret for his deeds, for he would tell the story of his attempted murder of his wife in a particularly open and shameless way, though equally remarkable for its clearness and coherency. His expression had lately been becoming slightly fatuous, and he is becoming reckless and improvident, giving away his spare clothing, etc.

**123. C. 19-1-01. Section 302. Acquitted on ground of insanity, 25-6. Killed one man and wounded two others with a sword. No other details. A case of epileptic insanity. Still in asylum.**

**124. C. D. 19-1-01. Acquitted on ground of insanity. Section 302. Committed murder. No details. Originally melancholic, was for**

many years sane, but vicious and unprincipled. Still in Asylum. In December 1907 gradually changed, did no work, cut off his hair in a curious manner, behaved and spoke absurdly.

**125.** M. 7-4-02. Unable to plead by reason of insanity. Section 302. "His wife in going out to make cowdung cakes, left their infant son 11 months old in his care, as she was in the habit of doing; on returning home she found the head of the child separated from the body. Two witnesses living close by stated, that they rushed in on hearing cries to find M. just finishing severing the head with a gundasa. Being questioned, he (M.) said the child had died as the two previous ones had died." Evidence was also given that he had been insane for some time and that his wife had control of money due to him, etc., on that account. Admitted in a condition of melancholia, now demented, still in Asylum, 20-1-08.

**126.** S. A. 15-4-02. Section 302. Acquitted on ground of insanity. On night of 17-10-01 this man asked his wife for 10 rupees; she refused to give it to him—(she was lying in bed). Sultan then struck her repeatedly on neck with an axe in quick succession until she died. It was proved that deceased and her husband were much attached and that she was of very good character. Accused directly after the murder, went out and told his brothers and later made a full confession—pleading later that he was not in his senses and knew nothing about it.

Evidence was given that for about a year accused had neglected his work, "was out of his senses," used to leave his house and quarrel with his wife without any cause, though previously he had been noted for his fondness for her. Also that he had been consulting a faqir as to his state. The mother stated that he used to stop working and go after faqirs. The brother stated that he used to come and wake him up at night without cause, and that he had ceased to say his prayers.

On admission he was obviously suffering from hypochondriacal melancholia, having delusions of abdominal disease, etc.; he became sane early in 1903 and has remained so to the present time.

**127.** D. R. 22-7-01. Section 304. Acquitted on ground of insanity. "For last 6 months said by neighbours to have been queer." "Had a quarrel with his uncle 4 months ago over some wood, struck him in back with a hatchet, the victim died later." At the trial was incoherent, etc.

A chronic maniac with aggressive tendencies. Still in Asylum.

**128.** R. B. 10-8-01. Section 302. Unable to plead. Murdered her child by throwing it into a well. Puerperal mania. Recovered, discharged to stand trial 18-7-02.

**129.** L. B. 13-8-01. Section 302. Acquitted on ground of insanity. During an attack of pneumonia rushed out of his house and struck another man, whom he met, a blow with a hatchet on the skull from which he died. No reason for the act, and the man on recovery had absolutely no recollection of what he had done. Sane in asylum. Discharged on 18-1-05.

**130.** S. 9-2-01. Section 302. Unable to plead. Had committed murder. No details. Known to have been insane in 1900, and dismissed service in consequence.

A chronic maniac now becoming demented, still in Asylum 1907.

**131.** P. 11-2-02. Section 302. Class 1a. Unable to plead. This man lent an adze to the man he subsequently murdered, and some days

afterwards asked for it back, but the "deceased wished to keep it;" they quarrelled, the deceased threw the adze at Parbhu, who thereupon struck him on the head and fractured his skull—all this occurring before 3 witnesses. "Accused shewed no sign of insanity in his previous life."

A miserable melancholic who recovered in August 1904, and is still sane and in the asylum.

**132.** F. D. 14-2-02. Section 302. Acquitted on ground of insanity. Suddenly came to a mosque on 30-6-86 and killed the Mullah, the evidence being that he, Fazal, was at the time mad. One witness states that he saw Fazal rushing about the fields like a lunatic the day the murder was committed, shouting and saying that he had become a Ghazi.

An unruly violent man, subject to recurrent attacks of mania. Still in Asylum, 1908. Very aggressive and cruel to other patients.

**133.** Y. 2-5-02. Section 302. Acquitted on ground of insanity. This man murdered on 26-10-06, the wife of a man with whom he had been quarrelling (about the produce of some land which Yakub had in common with his brothers), by hitting her on the head with a spade; the noise awoke the husband who was sleeping on an adjoining cot and he got up—Yakub is supposed to have mistaken the woman's charpoy for his—for he at once attacked the husband, who with difficulty succeeded in getting out of the house, and arousing the neighbours. Yakub does not seem to have made any effort at escape. At the enquiry he denied ever having been in the house and said that the whole affair was a got-up one between his brothers and the husband of the victim.

"From the behaviour of the prisoner at the regular trial, and the evidence of villagers as to his previous condition, the man was acquitted on the ground of insanity."

When admitted, was in a condition of acute melancholia—he has remained practically in this condition, silent, naked, statuesque until the present time, 1908.

**134.** L. 12-4-02. Section 302. Class I, *i.e.*, unable to plead. Murdered his mother on 7-1-02. No details. A melancholic with delusions of ill-treatment, etc., has rapidly become heavy, dull, stupid with no idea of space or time, and foolish, wandering speech. Still in asylum.

**135.** L. K. 28-5-02. Section 302. Class I, *i.e.*, unable to plead. It appears that this man and another assisted a third to kill his (the third man's paramour's) husband, after having made the two men insensible by drugs mixed with the food. The murder was committed with a hatchet. No evidence as to why the man was deemed to be insane then, nor is there any previous history of him. On admission, beyond being heavy, dull, difficult to make understand, or to speak, being curiously obstinate, talking when he did so in a rambling manner, he had few other symptoms, and as he rapidly improved and became absolutely sane—it was reasonable to suppose that he was then recovering from an attack of insanity, mania?

**136.** M. A. 16-9-02. Section 302. Class I. Unable to plead. This man murdered his wife with a hatchet without the least motive, and then went and gave himself up to the police. He murdered his wife while she was lying asleep by smashing her skull with a hatchet without the smallest motive. He had previously been on good terms with her, and she was the mother of several grown-up sons. Several members of his family had been insane. Admitted in a condition of melancholia; rapidly became sane. Discharged to stand trial on 14-12-03.



**137. Q.** 30-9-02. Class III. Section 302. Found insane while undergoing 7 years' imprisonment for murder. No details obtainable—the man himself on recovery described it as a "family quarrel." Admitted in a condition of melancholia from which he completely recovered early in 1905. Transferred back to jail, 22-12-06.

**138. F. K.** 22-10-02. Section 302. Acquitted on ground of insanity.

This lunatic was found to have killed his infant son and daughter, and to have attempted to kill his wife. He was apparently always supposed to be of weak intellect and said to go "raving mad" for a few days in a year; on this occasion he suddenly got up in the night, seized a block of wood and attacked his wife. She escaped; on re-entering the hut, the woman found her husband insensible (?) and the children lying, one dead, the other dying.

He has been sane while in the Asylum—admits his presence at the scene of the murder or rather being there that night, but persists in declaring that he knew nothing of it. No epilepsy yet noticed. Very ungovernable temper at all times. Still in Asylum.

**139. I. D.** 15-7-02. Section 307. Acquitted on ground of insanity. Formerly a Police Constable at Quetta.

"Accused beat his wife with a toka and would have killed her, but his wife's mother and 2 others intervened. The wife lived." "Accused admits that he committed the act, but insanity is pleaded on his behalf." At the time of trial he was able to give rational answers to all questions and was capable of making his defence. While employed at Quetta he had to resign on account of symptoms of insanity. He used to beat his wife in a state of frenzy and then weep over his act—he tore his clothes and did other irrational acts.

He had been in a condition of melancholia ever since entering the Asylum up to 1907. Now 1908 he works and is clean and respectful, but is foolish, unreasonable—always making some silly request in a retiring tone, and has very little recent memory.

**140. H.** 29-7-02. Section 304. Class III.

Found insane while undergoing a sentence of 10 years' imprisonment under Section 304. It appears that Haji had been insane before conviction.

No details of his crime, and he professes to have no memory of it. Whilst in Jail he attempted suicide. Admitted in a condition of melancholia which remained unchanged until the end of 1905. He is now foolish, rambling, practically demented, 1907.

**141. M. D.** 25-9-02. Attempted strangulation. Class I. Unable to plead. Epileptic.

An epileptic insane notoriously subject to fits of violence and excitement—arrested because without provocation he attacked a little girl in the bazaar and on that occasion became very violent. Since admission he had had frequent fits—usually in series—before these he slowly changes and following these becomes aggressive, violent and excited for several days—always talking and appearing as though the subject of great wrong and ill-treatment. Is then very dangerous. Never has any knowledge of his fits and persistently denies ever having had such a thing. Still in Asylum.

**142. I.** 6-10-99. Section 302. Class III.

Certified as insane while confined in Jail for murdering his own father. In Jail one night with little or no obvious provocation murdered a fellow-prisoner. A chronic maniac now becoming demented. Always very aggressive and violent. Still in Asylum.

The remaining cases include some of assault and violence which practically come under the same category as those of murder and attempted murder.

**143.** S. Age 32. 16-7-96. Section 326. Toxic insanity.

This man attacked his wife severely with an axe while in a state of intoxication from a mixture of spirits and *bhang*. Since admission he has been practically sane, and, was allowed to be discharged on 3-6-03, on security of his relatives.

**144.** M. S. 2-5-94, age 34. Section 325.

A case of chronic melancholia, who frequently refused to speak, always depressed, upon the point of tears. In March 1901 he suddenly improved for a short time and gave a coherent account of his assault on a man who, as he said, tried to strike him. He died in June 1901 of pneumonia.

**145.** D. Admitted when 26, on 29-4-95. Mania.

This man severely assaulted his wife. He remained for years in a state of chronic mania, subject to fits of violence, gradually becoming foolish and demented. Still in asylum and in same condition, 1-5-07.

**146.** M. S. admitted 16-2-92. Delusional mania, following toxic insanity.

Attacked a Divisional Judge in Court with a gundasa. The man originally suffering from insanity, due to Indian hemp, is now to all appearances sane, but has some delusion respecting the Czar of Russia and the Sikhs of Amritsar, to whom he occasionally writes long rambling letters. Still in Asylum 1908. He is given to taking intense dislike to people without obvious reason. Kept until able to make his defence.

**147.** S. N. Admitted when 28, on 29-3-94. Delusional insanity.

This man had a delusion that he should be made ruler of all the British possessions, and was being unlawfully prevented assuming his position, in consequence of which he was always attempting to murder Europeans, would, while talking sensibly and quietly, make a violent attack quite suddenly. Died of meningitis in Asylum, 18-2-02. Large mass of scirrhus cancer in front of vertebræ, found p.m.

**148.** S. D. 23-4-06. Section 325 (?).

In a condition of exaltation and excitement following on excessive study of the Koran, stabbed two men who had teased him, with a knife.

Admitted in a condition of simple mania from which he has now recovered.

**149.** Z. 10-10-06. Section 326. Unable to plead.

Caused grievous hurt to a man, woman and child with a spade, had been known to have been insane for some few days.

Assault was quite unprovoked, and the people were lying asleep under a tree.

A melancholic, with delusion of oppression by a certain Syad who has "shut his mouth and those of his children."

**150.** U. S. 8-5-97. Section 325.

This man, of good position, struck an E. A. C.—as he says in a religious dispute, but the evidence given was that the assault was quite unprovoked;

that Umar Shah had previously behaved at a shrine in a way which induced people to say that "his brain was affected," that he had been treated for this—that once, when Naib Tahsildar, he let off a gun (he states accidentally) and wounded a Zaildar.

His assault was preceded by a fit of moroseness and peculiar conduct.

Originally sentenced to 6 months' imprisonment but on appeal was acquitted on the ground of insanity. Sane while in Asylum. Released 2-11-01 unconditionally.

**151. A. M. 10-8-97. Section 325. Class III.**

This man was imprisoned for 2 years for striking "2 Jogis," as he says in a quarrel. No other particulars. An epileptic.

**152. N. S. Age 60. Admitted 30-7-98. Section 326.**

Acquitted on ground of insanity for an assault with a gundasa. A chronic maniac, becoming demented. Released on security, 6-8-03.

**153. R. 15-8-98. Section 326. Acquitted on ground of insanity.**

This man suddenly attacked his great friend in the middle of the night with a knife. Melancholia—complete recovery. Discharge, sanctioned on security, 12-4-00.

**154. S. K. Admitted 6-4-99. Acquitted on ground of insanity.**

This man, a constable, suddenly attacked another constable with his talwar. Said to have been suffering from mania, but always sane under observation. Discharged on security, 20-6-03.

**155. H. S. 6-10-99. Sections 328 and 325.**

Became insane while imprisoned. Admitted here for mania—recovered and discharged. Was an habitual prisoner.

**156. S. M. 17-7-90. Section 325.**

Murdered a Deputy Inspector with a knife. No details. A chronic maniac, always violently excited and aggressive, constantly attacking other patients. Died of acute nephritis, 1901.

**157. M. G. 26-10-06. Section 325. Unable to plead.**

"It is stated that since the last 6 months he had been subject to occasional fits of lunacy," and on 26-6-06 he assaulted a sweeper with a lathi, breaking the bones of his forearm.

A case of chronic mania (toxic). Still in Asylum.

**158. R. 25-4-06. Section 325.**

In a dispute about cloth, R. and 2 others attacked one Naru with sticks, beating him on head. Naru died, and R. was indicted under Section 325 and sentenced to 2 years' rigorous imprisonment; was sane enough at trial to attempt to establish an *alibi*.

Admitted in state of melancholia, daily declaring that he has some severe illness.

**159. N. 15-6-04. Section 302. Death sentence commuted to transportation for life.**

Reported as insane in the interval before confirmation of sentence of death. No history of crime (there is some reason to suppose the man quite innocent). Since arrival and up to October 1907 has been in a condition of melancholic stupor.

Later recovered, and is now absolutely sane. His recovery was accompanied by persistent tachycardia for some 2 months, which only gradually left him since 30-1-08.

**160. R. 14-6-00. Section 326. Class III.**

Found insane while undergoing sentence of 4 years' imprisonment under Section 326. No particulars of crime. Admitted in condition of melancholia—has remained until present time in asylum, unchanged, sits the entire day, every day naked, except for a blanket, and for the last year has a habit of adding up accounts by means of small pieces of brick—most foully abusive at the sight of anyone.

**161. I. D. 4-9-00. Section 325. Class III.**

Found insane while undergoing 5 years' imprisonment under Section 325. He is a man who was for years addicted to bhang, in the intoxication of which he once fell out of a railway carriage—sustaining serious injury to his skull, with a loss of memory for 2 months; his present condition seems to have gradually supervened on that. Admitted in a condition of simple mania; he had then appeared to have had before imprisonment complete loss of moral sense; there was no crime or misdemeanour that he was not daily committing—allowed to leave asylum to go to friends—as his conduct had much improved, 1906.

**162. L. 19-1-01. Section 328.**

An habitual criminal, convicted 3 times previously under Section 379 (twice) 394. Found to be insane while undergoing 7 years' imprisonment for Section 328. No details. Formerly an epileptic insane. Fits ceased after arrival. Escaped, 4-9-05.

**163. C. 18-10-01. Section 325. Acquitted on ground of insanity.**

Beat his uncle's wife with some pieces of wood. No other details. Was in the habit of constantly smoking charas day and night. Toxic insanity. Discharged on security, 14-3-06.

**164. I. D. 25-9-02. Section 326. Acquitted on ground of insanity. Age 55.**

This man had a petty quarrel with one Kashi Ram who rebuked him for abusing another. I. D. went at night while Kashi was eating and attacked him with an axe. Six of his neighbours gave evidence that for over a year I. D. had been insane and in the habit of annoying and attacking others. The offence was judged proved, but the man was acquitted on ground of insanity. A garrulous, old, chronic maniac, always excited, restless and talkative. Still in asylum.

**165. J. M. 27-9-00. Section 313. Acquitted on ground of insanity.**

While in a condition of chronic mania (toxic), in which he still remains, he went up (and without provocation) to where 3 British soldiers were standing together in the Bazar at Peshawar, struck one soldier on the head and beat another with a stick; when arrested, babbled something in reference to delusion of some property and a lawsuit. Still in asylum.

**166. J. S. 2-2-01. Class III. Sections 323 and 107, I. P. C.**

Released on appeal from offence under Section 323, and again recommitted under Section 107, and sentenced to a year's imprisonment. No details.

A chronic maniac with delusions as to a lawsuit pending. Still in asylum, unaltered.

**167. B. 2-10-01.** Sections 454 and 323. Simple hurt and house trespass. Acquitted on ground of insanity.

No particulars of crime. A case of toxic Insanity, rapidly recovering. Discharged sane, 3-1-05.

An unknown male, given in asylum name of BELA, age 48 (?). Admitted 11-12-04. Class I. Section 323. Mania, chronic.

The report received is blank—beyond stating that he is mute, and that he is said to have committed assault on a European lady. There are no other particulars.

**DURATION OF PRESENT ATTACK—unknown.** An old man of short stature who stands staring straight in front of him, who grimaces, points at various articles, or keeps his head bent on chest (he has a large goitre), but does not speak. Walks bent forward, half doubled up, belly rather prominent, ears fairly normal, head long anteposteriorly, flattened at temples. Sides equal, slight lateral curvature of spine, convexity to right, left hip a little raised, limbs natural, hands and feet rather large, feet flat, nose broad, bridge a little flattened, extremely broad mouth.

**EXTREMITIES,** natural but livid—toes and nails cracked and unhealthy.

**Chin prominent.** Lips red. Saliva retained.

**TEETH.** Filthy. Some molars deficient in lower jaw, also most of upper jaw teeth.

**PALATE.** Low and broad.

**SLEEP.** Normal.

**SPEECH.** Dumb to appearance—but he can speak—does so at night but nothing will induce him to answer.

**ATTENTION.** Can only be aroused by signs.

**REACTION TO QUESTIONS.** Deaf ?

Obeys when he can be made to understand.

**OCCUPATION.** Nil. Silent, bent-up attitude, clean, modest, not destructive.

8-1-04. Makes indecent gestures.

11-2-04. Quiet occasionally.

9-3-04. This man can speak, he was detected both singing and speaking, very clever in making signs for anything, but very obstinate, professes not to hear, but can do so.

12-4-04. Extremely shrewd, can understand everything, will neither speak nor work.

9-5-04. Frequently found chattering to himself as though in reply to hallucinations.

3-6-04. Always sitting wrapped up in a blanket, very shrewd and cunning, still will not speak.

2-7-04. Very shrewd, obstinate, peculiar habits, understands every thing, still will not speak.

4-8-04. Still silent, will do nothing.

9-9-04. Spoke with a patient yesterday.

4-10-04. Will never work, very shrewd and cunning.

7-1-05. Acts like a pettish child.

26-4-05. Behaviour childish; took up a dirty piece of paper and tore it into pieces slowly—just as a child would do.

24-2-06. The same.

24-5-06. No sense of decency; pretends to work, very imitative.

24-8-06. Clean in habits at present.

20-12-06. Always scheming and pretending.

18-2-07. Visual hallucinations. Declares that a certain faqir visits him at night assuming horrible shapes of a bird or beast.

- 7-3-07. Same visual hallucinations.  
 15-4-07. Unaltered.  
 30-1-08. Speaks, very cunning, shrewd, clean in habits.

**168.** G. K., age 30, Pathan. .Admitted 31-1-04. Mania.

Charged under Section 324, I. P. C., with making an attack on two people in Serai at Delhi with a knife—attack was uncalled for and without reason—was with difficulty apprehended. Certified to have been of unsound mind at the time.

**CERTIFICATE FROM DELHI.** "He has delusions, he was violent on first being kept under observation. He is reputed to sleep badly. He talks only Pushto and is difficult to understand." A very powerful man, plentiful black hair and beard, peculiar prominence and fulness of lower part of face, otherwise no abnormality, expression bright, eyes twinkling, no bodily deformity.

**PALATE.** Will not open his mouth sufficiently to allow it to be seen.  
**SLEEPS** well.

**SPEECH.** Is at times wandering, but usually coherent and sensible. Answers questions at once but often absurdly.

Understands everything said to him.

**MEMORY, RECENT.** Good.

No evidence of delusions.

**HOMICIDAL.** See history.

**OBEDIENCE.** Very truculent. Will do no work, silent, good-tempered, defiant, clean, modest, not destructive.

11-2-04. Working quietly with durzi, always smiling in a foolish manner.

9-3-04. Always has a silly fatuous smile, very quiet and heavy. Works a little now.

12-4-04. Very obstinate, works a little, very foolish.

2-7-04. Rather self-satisfied, a good worker, good-tempered.

7-9-04. Always ready to laugh, very silly, works willingly.

7-12-04. Quiet and foolish, works, manner simple, pleased with everything.

17-2-05. Makes silly replies to any questions.

27-7-05. Mentally unchanged. Came up to-day complaining of a boil in the axilla: which proves to be a large abscess.

25-10-05. Fantastic attire, foolish both in speech and behaviour.

24-2-06. Although improved, is foolish.

20-7-06. Foolish, takes no interest in anything.

24-8-06. In same condition, quite contented.

21-12-06. Obeys, speech fairly sensible.

26-1-07. Silly but otherwise well-behaved and clean.

15-4-07. Self-contained, quiet, clean.

**169.** K., age 40, a Mahomedan. Admitted 28-9-04 for Melancholia. Section 326.

This man, while under the influence of drugs, made a most unprovoked assault on a woman, striking her with an axe on the head. He pleaded that he did not know what he did, because he was under the influence of *bhang* and *charas*. He was originally sentenced to two years' rigorous imprisonment, but this was increased to four on 28-7-01, and the prisoner's present condition dates from his being acquainted with the fact.

"He is a *faqir* given to taking drugs" (*bhang* and *charas*) for many years. He was admitted in a state of Melancholia with slow and scanty speech, motionless, usually dejected and filthy in habits. On admission he

was in miserable condition of health with a sacral bed-sore ; he died unaltered on 15-10-04.

**170.** G., age 45, a Nain, admitted 11-2-05. Epileptic Insanity. Sentenced to one year's simple imprisonment under Section 107. Said to have been for the last six years a *baragi*, previously a shopkeeper. This man on admission was noted as being very aggressive, unable to sleep, constantly talking loudly and absurdly, and having some delusion that people wished to poison him, etc., of all his possessions having been taken from him. Under observation it appeared that his periods of excitement, etc., followed some of the fits of epilepsy, of which he had 10 to 12 a month ; at these times he was aggressive without provocation ; in the intervals he was fairly quiet and docile. Never any knowledge of his epilepsy.

**171.** M. K. Pathan, age 30 years, admitted 29-10-02 for Melancholia.

Attacked his old uncle with an iron rumba while he was asleep (no obvious provocation) as a result of which the old man died. M. K. looked at that time unwell, and after his uncle's death became worse ; when brought to court, he never answered any question, but pointed towards his stomach and "acted like an insane man."

**CERTIFICATE.** Is quite unable to answer questions rationally, seldom or never speaks, takes little or no interest in what is going on around and is constantly making signs with his hands and fingers. When asked a question, he generally points to his stomach. Is lost to all sense of decency and remains naked. Is very filthy in his habits, generally has an anxious, worried expression, and if left to himself wanders aimlessly about, is inclined to be very destructive, but has not been aggressive or dangerous while in jail. Said to have been insane since August 1902 ; in appearance is silent, filthy and dejective, head bent, fixed gaze on the ground, slow, lifeless walk. Lips and teeth tightly compressed, so that it is not possible to open his mouth or to examine his palate, eating well, sleeping badly, never speaking. He remained in this condition, silent, filthy, obstinate, same attitude and manner with peculiarly greasy, dirty skin and cold extremities until March 1903, when he began to improve, became better in appearance, held himself more erect and though still filthy began to speak a little. Next month, after a few days relapse into silence, he still further improved and by July was working. He had, however, a curious habit of coming up saluting, staring fixedly, and going away without explaining his object. A few months later he added to this a long speech in Pushto which it is not possible to understand. He has remained exactly the same up to the present day, 25-4-07. Quiet, hard-working, very self-contained, but whenever he meets one, making the same incomprehensible speech, which nobody, Pathan or European, has yet been able to interpret.

**172.** U. Epileptic, age 40 years, admitted 16-1-03. A' Bikanir beggar ; this man came begging to the compound of a Mr. M., his two dogs attacked him, Mrs. M. threw some lumps of earth at them to induce them to desist, one accidentally struck U., and he thereupon attacked the lady with a stick, breaking her left index finger.

No family or previous history of this man is obtainable except from himself, and as it is difficult to always make him understand, and he is partially demented, his own account is not very reliable. He states that he has had fits two or three times in the month for the last ten to twelve years, that these begin in a twitching of the left side of the face, that he has time to lie down, and then loses his senses. Observation of him here bears but this statement.

His voice is peculiarly whining and supplicating, his speech coherent, but after each fit he alters. He is very inattentive, dull and difficult to arouse. Since he has been in the asylum he has had from eight to ten fits

in the month, and each is preceded by a period of excitement in which he goes about beseeching, whining, crying, sometimes singing incomprehensible nonsense. Unable to speak intelligibly, petulant, irascible and unreasonable.

For the last two years his fits have been increasing in frequency, and he is more foolish and unreasonable. He is still in this condition and is in the asylum—1908.

**173.** N. S., Jat, age 32, admitted 7-3-03. Class II. Section 458. Epileptic.

This man on the night of 1-9-02 went to the house of one Mahila and beat him severely with a *lathi*; next morning he went out with a sword asking everyone to fight with him, and then inflicted severe injuries on another man.

During the enquiry in court was mute and behaved very strangely. N. S. denies all knowledge of any of these acts. Evidence given by his father was that he had always been liable to fits of aberration, when he would wander, cursing everybody. Once he fell down and when raised began cursing those around, and once was rescued from a pond. The accused had consulted "wise women" repeatedly to get rid of his affliction, and on this particular night he was suspected of going off into one of his fits, and the neighbours sat with him. No one in his family seemed to have suffered from insanity or any nervous disease. It, therefore, appears that he was an Epileptic, added to which he owns to have been in the habit of taking with his family every hot weather, a drink composed of *Bhang* mixed with certain vegetables.

He has several scars on the face and other marks of injury, but beyond being a little deaf he had no abnormality or deformity.

He appeared morose and dejected, but otherwise acted naturally and spoke sensibly.

On the 29-3-03 he attacked another lunatic, who accosted him.

2-4-03. He had his first fit in the asylum and was afterwards for a short time in a state of semi-stupor.

4-5-03. Another fit, no mental change before or after, he had no more fits, but suddenly on the morning of the 1st was found to be in a state of acute Mania. He went to the tailor's shop, seized the clothes and tore them to pieces; when spoken to, fell into a violent rage. He was put into a separate room and there lay motionless with one fixed attitude the whole day, refused food and had to be fed with a nasal tube.

4-6-03. He passed the day sitting in the same manner, resisting everything done for him. He was doused with cold water; given a strong purgative and as a result next morning, though dull and heavy, was fairly sensible.

12-6-03. Since the 6th this man has been suffering from fever, but has been so continually violent and maniacal that it was impossible to examine him. He attacks most murderously anyone approaching him, and though not very noisy, being indeed usually silent, he is extremely restless and ungovernable, he refuses food, and has to be fed through a nasal tube. About 8-30 A.M., though seen as usual a short time previously, he was found dead in his room.

*P. M.* On the left side in ascending frontal and adjacent parts of 1st and 2nd frontal Gyri was a hard mass with behind a cyst of brownish colour containing altered blood clot, the whole about the size of a nut; the harder mass behind this consisted of a piece of white detached bone, about the size of an 8-anna piece, below which was a mass of cicatricial tissue



gradually giving place deeper down to discoloured extravasated blood. The ventricle was not opened into. The mass was about one inch square and the same in depth, around it for a considerable distance forwards and backwards was much blood-staining. The interior of the skull looked absolutely normal and showed no trace of fracture.

I give the short notes of the case of a man who, following on a doubtful attack of insanity, has now for fourteen years been constantly possessed with the desire to kill by cutting, and who has even succeeded in effecting his purpose.

174. No family history of any kind is available of a reliable nature. At the age of 32 there is a doubtful history of his having been for three months strange and altered, given to cursing God and the Prophet, with delusions and exaltations saying that he himself was a Prophet. Following this it was noticed that he had become more irritable and quarrelsome, but this disappeared, and he was thought to be perfectly sane and normal. He is a barber: a friend of the family used to come daily to sit in his shop, and arrived as usual on the 3rd July 1887, when quietly, without any warning of provocation our patient came up behind him and cut his throat with his razor. Since that time up to 1900 when he was transferred here, he had been confined to jail as a criminal lunatic. He is and always has been a quiet, well-behaved man, speaking calmly and sensibly without the slightest of the usual signs of insanity, clean, decent, intelligent, without delusions or hallucinations, although a fluent liar and a very plausible speaker; but he is notwithstanding always trying to secrete knives or sharp pieces of tin, and with this make a murderous attack on some one, his one desire which he seems quite unable to combat being to kill by cutting some fellow creature. In June, 1900, he somehow managed to get possession of a razor, and without provocation made a murderous attack on a fellow-prisoner. On 30th October 1901, he secreted a piece of iron hoop and with this unsuccessfully attempted to cut another lunatic's nose off. Since then with stringent supervision he had failed to obtain means to effect his purpose and has remained the same; quiet, intelligent, well-behaved man he has always been for the last fourteen years.

## CHAPTER XLIII.

### SUICIDE AMONG INSANES.

Suicide has been in former ages and among different races considered meritorious, and even among some a religious duty. Under no circumstances can it even at the present day be considered as certain evidence of either vice or insanity. Least of all can it be looked upon in either light in this country.

Though there is no distinct clinical entity worthy of the name of suicidal mania, it is very frequent for a patient to kill himself (infinitely less so though in India than in Europe), in some forms of insanity, but it may be even in them obviously unintentional or accidental, in the latter case occurring in cases of general paralysis of the insane or acute mania, where a man to show his power and ability, leaps from a roof, or in his blind rage, as one sometimes sees

here, dashes his head against a wall or grating. Even when death does not result from these acts, very extensive injuries are often effected. Some would class such cases resulting in death, and also those that sometimes occur in delirium tremens and in epilepsy, and very rarely in hysteria, as impulsive—in contradistinction to the form in which death is effected after deliberation and careful preparation. This whole subject is most ably treated by Dr. Savage in Tuhe's Dictionary of Psychological Medicine, p. 1230.

Persons suffering from hallucinations may kill themselves as a result of these, very rarely in obedience to a supposed order, more often in desperation to avoid the "persecution," these inflict on them, sensory hallucinations, especially those having any connection with the sexual organs being the most potent in this respect; for a woman or man who believes that their sexual organs are being daily tampered with is almost invariably either dangerously aggressive or acutely suicidal.

Delusional insanity, either the primary systematized variety (paranoia) or the alcoholic variety or that following abuse of cocaine with ideas of persecution of being followed, watched, or with delusions of jealousy is a frequent cause of suicide. The primary disease is, however, much more likely to cause desire for revenge and attempts at murder. Of all varieties of insanity, melancholia is the most likely to cause attempts at suicide, and when a patient once shows evidence of this, it is extremely difficult to prevent him effecting his purpose; especially is this so, curiously enough, in the lighter varieties unattended with delusion, except and notably so in men with delusions of impotence, who are almost always suicidal.

In senile melancholia it is very common and in females at the climacteric and in connection with pregnancy. The tendency is increased by sleeplessness and some painful bodily ailment. It is usually effected in the early hours of the morning before dawn, and frequently in those actively suicidal, there is a tendency for it to be effected in some one way in preference to any other, for which there is often obvious opportunity. As before said, on account of the class of patients received here it is extremely uncommon in Indian asylums.

Instances of suicide; especially among Europeans and especially of the male, occur sometimes within a few days or a week of marriage; it will be always found, if the true facts came to

light, that in these cases there was an obsession of impotence, and that the sexual relations were impossible or unsatisfactory.

The few cases of men admitted here charged with attempted suicide are the following:—

**175.** K. S. 19-1-01. Section 309. No details. A case of melancholia. Died in asylum, 7-8-05 of cerebral hæmorrhage.

**176.** K. S., 41, a Musalman, admitted 25-1-05. Melancholia. Sentenced to 1½ years' imprisonment under Sections 326 and 309 on 15-3-04, for having inflicted grievous hurt on his wife, and attempting to commit suicide, he was noted soon after arrival in jail as being "mentally deficient," but there is no other information as to his crime or as to the onset of his insanity.

On admission he was a short, long-headed (anteroposteriorly) red-faced, sullen-tempered man, who when approached shuts his eyes, and had the appearance of trying to withdraw into himself, and to shrink up like a hedgehog.

He refused to speak, and it was impossible to arouse him, though he obviously understood everything said—he sat all day in a corner doing nothing, passing all his excreta under him, usually naked. He appeared by his gestures, etc., to have visual and auditory hallucinations. Beyond, in 1906, beginning to work a little and to move about, and later to become clean in his habits, he was not altered up to the present time, May 1907.

**177.** H., 40 (?), a Jat., admitted 25-1-05. Melancholia. Sentenced to one year's simple imprisonment under Section 309 for having placed himself on the railway, though he only succeeded in getting his hand cut off.

A tall, grey-haired man, weak and trembling, fixed expressionless face and untidy clothes, scanty speech, deficient comprehension, and some loss of recent memory.

He became gradually more foolish and bodily feeble, and is still in the asylum, May 1907.

**178.** J., age 50, a Rajput, admitted 24-12-04, for senile mania. Acquitted on ground of insanity on charge of having jumped down a well, supposed to have become insane on account of several deaths from plague in his family.

Certified as being depressed, refusing to eat or drink, being anxious to kill himself, and giving incoherent answers to questions put to him, taking no interest in anything.

He was a miserable blear-eyed, dejected-looking old man, whose conversation was restricted to vague requests to be hanged, etc.

From admission he suffered greatly from chronic dysentery and died of that complaint on 18-8-05.

**179.** R. H. 22-8-01. Attempted suicide. Incapable of making defence.

Attempted suicide by cutting his throat with some sharp instrument—afterwards tore off the bandages and scratched open the wound in his neck. Admitted as a melancholic, became demented, and is still in asylum, 1908.

**180.** J., Musalman, punkah coolie, age 21. Admitted 3-12-05. Class I. Section 309, I. P. C. Melancholia.

"Has, it is alleged, been arrested by the Police on 11th September on the line at Sher Shah, N.-W. R., in the act of attempting to commit suicide on the line—the C. S. states that Juman is suffering from melancholia." Incapable of pleading Section 466, C. P. C., case reported to the Local Government.

**CERTIFICATE.** "He remains quiet, and it is with difficulty that he speaks. He is depressed and melancholic," that he is always depressed in his mind and wishes to commit suicide. His habits are dirty.

A black-haired, dark-complexioned youth, with an air of misery and dejection, who shuffles slowly along, or stands still, staring miserably before him.

Walks slowly, but naturally. Skin, cold, dry. Extremities, rather livid. Lips, closed. Saliva, restrained. Teeth, good. Palate, high. Eats very badly, can with difficulty be made to take his proper amount of nourishment. Sleeps badly.

It is only with the greatest difficulty he is made to speak, never speaks of his own accord. Often will not answer, though when he does, is coherent and sensible, but when asked his village, says Magistrate ilaqua. Can give no account of himself.

Very difficult to arouse. Frequently does not reply, very slow in doing so—can give absolutely no coherent explanation of himself or his family—understands, professes to have no memory, but this only seems another instance of his general difficulty in replying and speaking, still his memory when repeatedly tested is not good.

**DELUSION.** Does not speak sufficiently to say decidedly, but gives no evidence of having any.

**SUICIDAL TENDENCY.** Yes, attempted suicide.

**HOMICIDAL TENDENCY.** No. Obeys when he understands, cannot be got to do anything.

**ATTITUDE.** One of misery and dejection.

12-12-03. Salaams properly on seeing anyone—eats his food, clean in his habits, very miserable in manner and appearance, speaking a little, was at first always naked, now no longer so.

8-1-04. Works under supervision ; very difficult to make understand, not so miserable.

11-2-04. Brighter, replies more quickly, easier aroused.

9-3-04. Very hypochondriacal.

12-4-04. Came up to-day and began weeping—*bahut gharib tu ghar men jao*, but could give no explanation of what he meant. Occasionally talks a little sensibly.

9-5-04. Sane.

7-12-04. Sane.

7-1-05. In hospital with pneumonia.

17-2-05. Following his recovery from pneumonia, the man became altered, he is more amiable, obstinate, talks foolish, rambling nonsense.

19-8-05. Slightly improved and working.

22-11-05. Sane.

21-12-06. In hospital with pneumonia, left lower lobe and right middle.

22-12-06. Died in above condition.

## CHAPTER XLIV.

## THEFT BY INSANES.

*Kleptomania.*

To the impulsive tendency to steal exhibited by so many chronic maniacs, imbeciles, and other insanes, has been added by some writers a special variety of insanity, kleptomania; characterised by the possession of an irresistible impulse to steal, attended by no other symptoms of intellectual derangement, an example of a pure impulsive insanity. Some cases of hereditary transmission of an analogous tendency have been recorded, Bucknell and Tuhe's Psychological Medicine, p. 279, but such an affection is of extreme rarity, and no example of it has ever come under my notice in the asylums or jails of India. Stealing on the other hand is fairly common among insanes, and the subjects of this peculiarity it will be found fall into 9 classes:—

(1) Europeans in the incipient stages of general paralysis of the insane often steal; many of these, however, believe that everything belongs to them, that they have universal power and authority, and that being so, their appropriating any article they fancy is scarcely to be wondered at.

(2) Some patients with simple mania who stole (see Chapter on Mania), have come under my observation. As these speak coherently, have no fixed delusion and do not suffer from hallucinations, and often appear to inexperienced persons fairly rational, their habits in this respect are liable to be misinterpreted, but if kept under observation, their general exaltation, unreasonableness, constant restlessness, flighty manner, objection to taking food, to any sort of control, and their inability to follow any fixed occupation, their garrulousness, and the dislikes they take to those about them, their emotional instability, all combined with this being at variance with their former habits and behaviour and the condition being of rapid onset, should enable them to be easily diagnosed. Such patients will appropriate anything and will be always ready with some plausible excuse for their conduct, and cannot be convinced of the impropriety of it.

(3) Imbeciles and demented will, of course, steal for no motive whatsoever; it is not, however, a common failing; imbeciles more usually destroy articles and demented are usually lacking in sufficient interest to actuate them to take them.

(4) Moral imbeciles, as already several times stated, will commit any vicious or improper act, and stealing is one of them; some have a great predilection for this crime, but then they are usually notorious, and have been so from early childhood.

(5) Some insanes will steal, it is conceivably possible, under the influence of a delusion or hallucination of voices urging them to do so; such are of extreme rarity and always present obvious indications of insanity.

(6) In those cases where, after recovery from a severe head injury, the patient is totally altered in habits, disposition and morality, he or she will sometimes steal just as they will do any other vicious act. They can indeed be only regarded as "moral insanes."

(7) Epileptics are, as is well known, more prone to deeds of violence, but some have the peculiarity of always stealing and hiding the belongings of others; several cases of this character have been in this asylum; one in particular was always stealing the shoes, plates, any articles indeed of his fellow patients, and burying them in the ground. Such patients do not always even take the trouble to do so secretly.

(8) Most frequent of all in asylum patients, are certain insanes suffering from chronic mania, some of whom will spend their entire time in stealing everything they can find, and either hoarding or burying them; in my experience this tendency is more common among women.

(9) It has been claimed in Europe that thefts are sometimes committed by pregnant women from irresistible impulse, as extension of the cravings, longings, for certain things from which such people often suffer, but it is more than doubtful whether any one could reasonably urge such an excuse in extenuation of their act.

Most of the patients coming under any of these headings present symptoms of mental defect, obvious enough to render their distinction fairly easy, but when this is not the case, all the attendant circumstances have to be taken more particularly into consideration, especially when, as sometimes happens in Europe, people of fairly good position, able to command expert opinions, caught stealing from shops, etc., claim exemption for the consequences on the ground of insanity.

It is easy enough, of course, to say, that in a fat, well-fed individual, who in an institution habitually steals food of every

description, most of which from repletion he is unable to eat, that in him the symptom is only another evidence of his insanity, or that the dement and chronic maniac, in the same way that he collects bits of glass, half bricks, twigs and rubbish, only steals clothes, shoes, platters and blankets from a similar tendency, but in others it is not so evident; still, when a man or woman, previously of correct life, steals valueless articles, steals purposely things, the possession of which can bear no possible weight against the risk he runs of exposure and detection, or if well off, appropriates articles of trivial value, and when, instead of making use of them, hoards them from simply what can only be compared to the magpie's like habit of collection.

It may fairly be questioned whether such a one has not passed the borderland of insanity. In all similar cases, the question of the manner in which the act was committed, is also of importance. Did he seize a favourable moment to effect his purpose, and to conceal it? Was the act denied on detection, or followed by plausible excuses for its commission? What use were the articles put to? All these combined with his family history, whether this is one of insanity, epilepsy and nervous disease, the antecedents of the accused himself, especially in relation to whether he had ever previously been affected with any mental affection, have to be very carefully considered, and failing exceedingly strong presumptive evidence to this effect, it would be more than unjustifiable to favour a plea of insane stealing unless undoubted symptoms of mental disease or imbecility could be proved as existing in the patient, indeed failing these being evident, however strong the presumptive evidence, the writer certainly would not advocate the question of irresponsibility unless the accused had been previously insane, when any vicious tendency in spite of apparently complete recovery is always possible.

#### EXAMPLES OF INSANES CHARGED WITH STEALING.

##### 181. Age 25. Admitted 9-5-96. Epileptic.

Originally convicted for theft which he states he committed after an epileptic fit. Fits about three times a month, sometimes oftener; these are occasionally followed by outbursts of noisy excitement and violence. Still in asylum and in same condition. But is lately becoming more violent after some of his fits.

##### 182. T. C., age 35. Admitted 19-1-04. Theft.

Originally convicted for theft when in a condition of melancholia. For years appeared silly, foolish, with fits of excitement, tendency to go naked.

But in 1902 gradually became sane, and was discharged the next year on security.

**183.** K., age 30, a Hindu shopkeeper. Admitted 13-10-03, charged with theft (no particulars), but being found insane in appearance, this was postponed. Mania, later becoming demented.

A restless, inattentive, chronic maniac with rambling conversation, who rapidly became foolish and demented, under observation. He is still in the asylum and in that condition, 13-5-07.

**184.** J., age 35, a Mahomedan. Admitted 30-6-01. Theft at night; Section 380. Acquitted on ground of insanity.

Accused was charged with stealing a pony from a compound at night; he himself states that in a fit of insanity he took a mare from the house, let it graze on some corn, brought it back and was then arrested. He was notoriously subject "to fits of insanity, due to excessive drug taking."

His father's brother's son was said to be insane. Though the man himself denied the use of drugs, the history of the neighbours is probably correct, for the man was sane on arrival here, and remained so here until permitted to be discharged on the security of his friends on 1-4-06.

**185.** S. M., age 40, a Jat. Admitted 3-5-05. Epileptic insanity.

Sentenced on 19-1-07, Section 379, theft, to four months' rigorous imprisonment. No history of him before conviction. In jail he appears to have been obstinate and unruly, refusing to work or to allow himself to be weighed.—abusive to others—attacking the others on the slightest irritation. Had a delusion that everybody abused him though he had definite "lucid intervals." Tendency to roam aimlessly about. Under observation it appeared that he had epilepsy at variable intervals, the fits being preceded by a tendency to be violently aggressive, but after some four months it was noticed that he was in the habit of making sudden murderous assaults without any provocation, quite apart from the incidence of epilepsy, and that he was at all times violently passionate over trifles.

On 20-8-03 he made a sudden homicidal attack without warning or provocation on a sweeper. No epilepsy. Similar assaults occurred at varying intervals. He has remained in this condition always morose, irritable and homicidal up to the present time, the only change noticeable being that his memory has begun to fail rapidly the last six months. The fits of epilepsy are very variable—some months he has as many as nine, and at other times an interval of three to six months will pass without any having been noticed, though rarely a month goes by without his murderously attacking some one. He is, if anything, less dangerous when the fits are frequent.

**186.** M. K., age 30, a Mahomedan. Admitted 5-8-01. Crime, theft.

Trial postponed as unable to plead. "Delusional" mania.

Said to have been insane for many years—to be given to incoherent speech, to constant laughing and singing, to making a noise, going about naked, and to be lost to all sense of decency.

This is a well-made man, in the best of health and spirits. Constantly exalted, gesticulating, and talking facetiously and cheerfully. He has a delusion of which he is always ready to talk as to his being the son of Ali Hosein, and therefore that he will be a king after the day of Resurrection; he is so full of good spirits and his delusion, that no history whatever is obtainable from him. Though usually laughing and good-tempered, he for some unknown reason occasionally attacks people without warning or provocation; while laughing and talking he will suddenly pass into a violent rage and attack those near him; at all times he does anything he feels inclined, and for this



reason is exceedingly troublesome and dangerous; lately he has taken to remaining always naked. His aggressive tendencies constantly increased, so that to prevent him assaulting others, or being assaulted in revenge, it is ever necessary to keep him alone in room. He is still, 30-1-08, in the asylum and unaltered.

**187.** U. K., age 35, a Mochi. Admitted 19-8-04. Sentenced on 7-9-03 to three years' rigorous imprisonment for Section 379. Theft. (Epileptic insanity.)

In jail this man was found to be an epileptic and of aggressive habits, always ready to fight anyone speaking to him, and of very violent demeanour. Refusing to do any work. In the asylum between the fits which occur about 8 times a month, he is sensible in speech and manner, though he was occasionally aggressive at first—following the fits he is stupid and his speech becomes incoherent for a time—beyond becoming more dull, he has remained unchanged up to the present time.

**188.** M. S. Mahomedan, aged 38. Admitted April 5th, Class I. Section 380. Simple mania.

M. S., was charged under Section 380 with stealing potatoes, valued at three annas, and also under Section 411, I. P. C., for keeping in his possession some grave stones, valued at Rs. 50, from a graveyard in vicinity. The Assistant-Surgeon declared the man to be insane, and later the Civil Surgeon certified he was unable to make a defence. The matter was reported to the Punjab Government, who issued orders for his admission here.

Nothing definite obtainable from the patient.

**DURATION OF PRESENT ATTACK**—unknown. A contented, happy, foolish person, talking constantly in a whispering voice—very restless. Deformity *nil*.

**SLEEP.** Good. Speech, very rapid, loquacious, mostly nonsense. General glandular enlargement, slight bruises over right arm.

**ATTENTION.** Fair. Answers to questions. Fair.

**COMPREHENSION OF QUESTIONS.** Fair.

**MEMORY, REMOTE.** Fair.

**MEMORY, RECENT.** Fair.

**DELUSION.** That he is a man of noble family. He further states that his voice has gone—hence his talking in a whisper. Obeys. Is noisy, restless, clean, modest, not destructive.

26-4-05. Noisy, restless, destructive to trees.

25-5-05. Never alters, a buffoon.

16-6-05. Always the same.

27-7-05. Always playing the fool.

29-8-05. The cook's guide of the criminal section.

21-9-05. Very cheerful and communicative.

25-10-05 to 20-12-05. Always the same; buffoonery.

23-1-06. Excited, abusive, destructive, mischievous, has had to be kept apart.

24-2-06. Very destructive and aggressive; attacked Gaman Shah.

24-3-06. Less troublesome during past month.

19-4-06. The same.

24-5-06. Less troublesome; acts the buffoon constantly.

10-6-06. Transferred to non-criminal class.

21-7-06. Discharged on the security of his brother.

**189. A. 7-1-02. Section 411. Class III.**

Found insane in jail while undergoing one and-a-half years' imprisonment for receiving stolen property. A melancholic. Discharged cured, 9-6-02.

**190. K. D. Admitted 25-9-04, when 25. For mania.**

This man was originally imprisoned for theft. No particulars. He relapsed into a condition of chronic mania. Constantly excited, incoherent and filthy. Remains practically in the same condition to the present day.

**191. J. Age 30. Admitted 5-5-96. Section 379. For mania.**

This man is an habitual criminal, admitted after undergoing imprisonment for theft for chronic mania. Later became weak-minded, but at intervals is very aggressive, attacks people without provocation. Still in the asylum in the same condition.

**192. H., Musalman, age 20. Admitted 28-9-03. Under trial under Section 379. Beggar. Chronic mania, with dementia.**

PREVIOUS HISTORY and account of onset of Insanity, none given, and the man's own statements 29-9-03 are unreliable.

16-2-04. Charged with committing offence of cattle-lifting; found to be insane and incapable of making his defence. Supposed to have gone insane after his father's death. Said to have got on to a pony in the village and ridden away with it. The family deny that he ever took charas. No family history of insanity.

He has been under observation for insanity from 10-9-05. He answered questions put him in a proper manner at first. He has a great tendency to carry off things which are about. He took a Police Sergeant's shoes away on the morning of the 4th September. The same evening he took the shoes of the Assistant Jailer from the office. On the 7-9-03 he was caught carrying off the shoes of some under-trials when on parade.

On the 14-9-03 he was making a great noise in the cell and was later caught trying to climb the walls of the cell courtyard. "He does not sleep at night, starts making a great noise in his cell towards morning. He does not answer questions now in a proper manner, talking a great deal of nonsense to himself for the past three days. He has taken to a dirty habit of rubbing his body with his own excrement and urine. He has torn up four blankets in the cell."

**DURATION OF PRESENT ATTACK. Unknown (April 1903).**

A healthy-looking youth, without any respect of persons, very restless, always singing, stands staring around him, very dark complexion.

Answers questions stupidly, asked why he was arrested—says "Yes, in jail"—asked what he stole, says "for 9 years"—occasionally he answers a question sensibly. Asked when he came here—replies yes.

ATTENTION. Very difficult to attract. Replies are absurd, often bear no relation to the question, understands what he is asked if the question is frequently repeated.

**MEMORY, RECENT. Bad.**

MEMORY, REMOTE. Cannot be ascertained. Obeys when he can be made to understand, does what he is put to if of a simple character. Always singing; stands stupidly staring around. Clean, modest, wears clothes, not destructive.

10-11-03. Lately excited, restless, tears up his clothing, annoys the others, very filthy, this has been only for the last month before which he was working quietly.

16-11-03. Returned to Gujranwala to stand his trial.

16-2-04. Re-admitted under authority of letter No. 1451, dated

15-12-03, from Judicial and General Secretary to Government, Punjab, to Commissioner, Lahore.

Quiet, clean, decent, very dull and reticent, gives a coherent, and truthful account of his crime; memory of recent events, good, much more sensible than on last admission.

9-3-04. Very stupid and dull, working well and sensibly.

2-7-04. Says that he has plague, smiling all the time, in the best of health and spirits.

4-8-04. Silly, foolish, very complacent.

24-5-05. Sane, foolish, and slow in speech and action.

20-12-05. In a state of mild, acute mania, excited, abusive, not filthy, noisy, made a savage attack on a keeper some time ago.

19-4-06. Aggressive during month, had to be kept apart.

28-8-06. Quieter and working well in cook house, excitable.

18-2-07. Memory for time very defective, says he has been here only ten months.

15-4-07. Unaltered.

193. G., Jat. Admitted 21-6-05. Class I. Section 394, I. P. C., Section 466, C. P. C. Chronic mania.

The Magisterial record states:—On 31st March 1905, G. met Hasso on her way from her own village to another. He struck her with a lathi and took away her *hasli* and her clurian. Buta and Lehna Singh came to her assistance and caught G. and handed him over to the Police. He was indicted under Section 394 for the above offence, but as he appeared insane he was sent to the jail for observation. The Civil Surgeon reported that the man was insane and incapable of making his defence. He was thereupon committed to jail under Section 466, C. P. C., and finally as there was no accommodation for him in the jail, transferred to the asylum here in anticipation of the sanction of the Government.

Patient states that he became mad about two and-a-half months ago about the time of his marriage. He says (this is very doubtful) that he drinks bhang and smokes charas. He was under the influence of bhang when he committed the above crime; he denies the details.

(a) Noisy, destructive, dirty in his habits.

(b) Does not sleep at night, tears his clothes and bedding, drinks his urine and rubs his excreta over his body.

**DURATION OF PRESENT ATTACK**—two and-a-half months.(?) An under-sized, dark man, with an extremely low type of head, the forehead is very small, being less than one inch in depth at the centre. The eyebrows are bushy and meet the hair of the scalp which is prolonged down over each temple.

**ATTENTION.** Fair.

**REACTION TO QUESTIONS.** Good.

**COMPREHENSION OF QUESTIONS.** Good.

**MEMORY, RECENT.** Good.

**MEMORY, REMOTE.** Good. Stated in record that he had not been previously known to be dangerous to others. Obeys, silent, filthy, not modest.

27-7-05. Has had an attack of syncopal heat apoplexy, heart sounds weaker and have remained so. Has been acutely maniacal most of the month.

19-8-05. Hospital, very ill with acute enteritis.

21-9-05. Always naked, extremely filthy.

3-10-05. The acute enteritis for which patient was admitted into hospital in July continued despite treatment, becoming chronic.

Patient was further the subject of cardiac disease (irregular and intermittent action), frequently having attacks of syncope. Died to-day at 11 A.M.

**194.** M. W., age 31, a Mirasi, admitted 31. (Chronic mania.) Sentenced on 28-4-98 and 21-12-01 for dacoity and being in possession of arms to an aggregate of eleven years' rigorous imprisonment.

"The prisoner bore an extremely bad character both before and during imprisonment, being always regarded as most troublesome and dangerous." No history of the commencement of his insanity in jail is obtainable. He was certified as having delusions of wealth and power, imagining that he had military forces at his command, and being noisy and constantly muttering sounds that are not intelligible.

Beyond being more amenable in the asylum, and gradually settling down to work, he has remained in this state to the present day. A tall, finely made man constantly smiling and cheerfully muttering unintelligible gibberish, very defiant and truculent to those who do not know how to humour him, but always clean and modest. At first he was inclined to be aggressive, but has gradually quietened down, and is now foolish, good-tempered, unintelligible, but a useful worker.

**195.** N. A., age 25, a Mahomedan Arian. Admitted 22-12-04 for melancholia.

Sentenced to five years' rigorous imprisonment on 30-4-04 for dacoity. No particulars.

He was certified as having become melancholic in jail, but being sane on arrival at the asylum, and continuing so was retransferred to jail on 20-12-05.

**196.** K. D. Theft. Admitted when 25, on 25-9-94.

Originally convicted for theft, term expired. A chronic maniac, still in asylum, May 1907.

**197.** A. 30-1-97. Formerly imprisoned for theft.

No particulars of crime—became insane in jail or rather insanity, recognised there he was an epileptic. Died of pneumonia, 29-4-01. Always liable to commit sudden violence.

**198.** M. B. 14-9-87. Unable to plead on account of insanity.

Accused of having stolen a pair of bullocks. A melancholic. Still in that condition in asylum.

**199.** J. 21-4-98. Class III.

Term of imprisonment under Section 378. No particulars of crime.

A demented maniac, still in asylum.

**200.** G. 24-7-98. Acquitted on ground of insanity. Section 380.

Stole half-seer of ghee. Admitted in a state of mania, recovered for some months; again recovered after a recurrence. Discharged 25-4-06.

**201.** M. B. Class I. Section 392. Unable to plead. Admitted 17-3-99.

Beat a small boy severely and stole his ornaments. A chronic maniac. Delusions of having 4 hands and 4 feet—unchanged, still in asylum, 1907.

**202.** G. M. Admitted 19-5-99. Insane and unable to plead.

Accused of theft of clothing while in a state of mania—rapidly recovered. Discharged to stand trial, 24-3-00.

**203.** A. D. 2-3-96. Theft. Section 379. Unable to make her defence.

This woman, it is stated, "used to wander about the bazaar as if mad," and was caught in the act of stealing some ornaments from a house; when arrested, she was found to be in possession of ornaments, clothes and eatables for which she could not account. Has remained in condition of chronic mania in which she was admitted.

**204.** C. D. 27-7-00. Theft. Acquitted on ground of insanity.

While in a state of simple mania removed a mare from a tonga which had been tied up in the street; when pursued and captured, could give no reason for his action. Now sane; still in asylum, 1907.

**205.** H. Admitted 31-3-00. Class III. Section 458.

A case of melancholia—became insane in jail when he was undergoing imprisonment for Section 458—was an habitual criminal. Recovered and left asylum 12-6-01.

**206.** B. S. 4-1-07. Section 379. Unable to plead.

Accused of theft—stole a *lota* worth one rupee, and at another house on the same day a cloth worth 12 annas, was caught red-handed but was obviously insane. Admitted in a condition of acute mania from which he is now gradually recovering.

**207.** R. N. 14-4-00. Section 107. Class III.

Found to be insane while undergoing 1½ years' imprisonment under Section 107. Admitted as a chronic maniac. Died 10-4-02 of dysentery.

**208.** I. D. 1-5-00. Section 379. Class III.

Found insane while undergoing a sentence of five years under Section 379. No particulars of crime.

**209.** T. Admitted as a chronic maniac with delusion of being 10,000 years old, etc. Still in asylum. Demented.

**210.** K. SINGH. 24-4-00. Section 380.

Found insane while undergoing two years' imprisonment under Section 380. No particulars of crime. Admitted in condition of chronic mania; later became demented. Died of acute pneumonia, 1-1-06.

8-4-00. Section 379.

Found insane while undergoing 13½ months' imprisonment under Section 379. An epileptic insane. Died in asylum.

**211.** G. 27-9-00. Section 379. Age 60. Found unable to plead.

On 12-1-00 at midnight stole the cooking vessels and shoes of three constables, found to be in a condition of mania with a delusion that his son's marriage was the next day, and that he must go at once for it. Died suddenly, 7-8-01.

**212.** T. S. Age 60. 19-1-01. Sections 457 and 379. Acquitted on ground of insanity.

No details of his theft. Described as a "chronic" maniac, but has been always sane while in asylum. Discharge permitted on security, 1-5-03.

**213. D. 16-4-01. Section 379. Class III.**

Found insane while undergoing four years' imprisonment under Section 379; certified as suffering from mania. Discharged cured, 8-11-04.

**214. C. 24-6-02. Theft. Acquitted on ground of insanity.**

"He remembers running away with a camel, but says he was told to do so by a priest or faqir for the sake of going to Heaven."

While under observation before trial had several periods of acute excitement. It appears that a man was feeding a camel; accused came up, struck the boy and took off the camel, but the boy informing a man in a field close by, the accused was chased and caught—he admits the offence; appeared to be weak-minded from admission—liable to fits of restlessness with destructive tendencies. During the latter part of 1906 he improved so much as to be regarded as sane, but all this year he has been practically in his former condition. He is a wandering Bikaniri and no history of him is obtainable.

**215. A. D. 21-10-02. Theft. Class I. Unable to plead.**

Arrested for stealing a blanket valued at Rs. 3-8; he had had six previous convictions for similar offences, and had undergone an aggregate of six years in jail and 78 stripes.

"He was served with a notice of ejection under Section 210, C. P. C. He paid no attention to this, and was arrested shortly after for theft, present offence." "A. D. is of weak intellect, and from his demeanour in court, it is clear that he has not the slightest sense of responsibility for the offences he commits," though otherwise harmless and seems unable when at liberty to refrain from thieving.

Regarded on admission as a chronic maniac—much improved in a few months, and was discharged to stand trial on 19-6-03.

**216. S. D. 25-10-02. A dumb microcephalic idiot; caught red-handed in the act of stealing clothes from under a sleeping man's head. Acquitted on ground of insanity.**

**217. Mst. M. B. 10-10-84. Section 379. Unable to plead. A harmless dement, found one night in a European's bedroom with "his wife's clothing on." She was then incoherent and could give no account of herself. Has remained in this condition in the asylum.**

**218. Mst. D. 18-1-88. Section 379. Acquitted on ground of insanity.**

This is an epileptic insane accused of theft; no details. She is continually stealing everything valueless or otherwise in the asylum.

**219. B. 5-4-94. Section 395. Underwent four years' imprisonment for dacoity. No other particulars. A chronic maniac. Still in asylum.**

**220. K. 15-9-05. Acquitted on ground of insanity. Section 379, I. P. C., and Section 55, C. P. C. Accused of stealing two dogs—had been previously found wandering in the compound of a house. Admitted in a state of simple mania from which he recovered rapidly. Discharged 2-8-06.**

**221. G. Age 52. Faqir. Class III. Sentenced 14-7-99 to one and three-fourth years' rigorous imprisonment under Sections 457 and 380. This man has had two attacks of insanity; ultimately he became incoherent, noisy, destructive and filthy. Delusions of having Rs. 40,000 in his possession. Is usually naked.**

From June 1900 he began to improve and was discharged sane on 8-12-00. It is worth noting that this man's second attack commenced quite suddenly in jail, with excitement, irritability, delusions and suspicions of his fellow-prisoners. His friends stated that he once set fire to a quantity of good matting he had for sale.

**222.** B., Rajput, age 30. Admitted 17-12-03. Class II. Section 457, I. P. C. Melancholia.

"The lunatic was seen going into the godown of a European house."

**CERTIFICATES.** "Smearing faces on body and walls, tearing his clothes, gives no answers to questions. Does not sleep at night, makes a noise and disturbs other persons at night." An unhealthy-looking man of medium height. Blear-eyed. Head normal shape.

**WALK.** Slow and heavy, otherwise natural. Skin cold, dry, scaly; nails cracked.

**EXTREMITIES.** Livid.

**SLEEPS.** Naturally.

**SPEECH.** Very limited; very low voice; can only be made with the greatest difficulty to reply, and then does so in monosyllables. He can or will give no account of himself.

Always fixed on his own thoughts. Most difficult to make answer. Understands; but every question has to be repeated at least twice.

**MEMORY, RECENT.** Good. Obeys, will do no work—silent—sits the whole day gloomy and solitary, will do or say nothing. Clean, modest; not destructive.

8-1-04. Very filthy in his habits, eats faeces, is very unreasonable, makes whining statements, very difficult to understand, eats well.

9-5-04. Very filthy, will do nothing, very unreasonable and obstinate.

5-9-04. This man will do nothing but sit alone and in a retired spot playing with earth the whole day. He does not speak unless addressed, and then the conversation, though wandering, is chiefly directed to complaints as being styled Bhagwan which he declares is not his name. Talks very rapidly.

3-11-04. Always chattering to himself and alternately complaining and abusing.

27-7-05. Dirty: torn clothes.

21-9-05. Filthy; never alters.

20-6-06. Excited during month.

20-10-06. Died of chronic dysentery in hospital.

**223.** F. E., age 27, a Mahomedan Mali. Admitted 15-11-04. Acquitted on ground of insanity. An imbecile. For Section 456. Lurking house trespass.

"Caught in a house; nothing had been touched; he was merely standing doing nothing; accused admitted to jail." No previous history obtainable.

He remained in the condition of imbecility in which he was admitted until 19-11-06 when his discharge was sanctioned.

**224.** B., age 50, Mahomedan. Admitted 7-1-05. Mania. Unable to plead by reason of insanity.

Charged with theft of a bullock. No other particulars. Certified as being filthy in habits, destroying any clothing and bedding with which he may be supplied, and as being noisy and incoherent.

"A grey-haired, feeble old man, who from time to time cries and howls for hours without obvious reason. "Has a curiously fixed staring gaze."

Speech wandering and disconnected, usually crouched up in a corner alone doing nothing; very filthy in habits.

He was in hospital practically from the day of his admission and died collapsed on 28-1-05.

**225.** D. G. 25-3-99. Became insane while in jail.

Class III. Section 457. A chronic maniac, later becoming demented; still in asylum.

**226.** A. R. Had broken a street lantern.

Admitted 6-6-99. Section 426. Secondary Dementia (after melancholia). Still in asylum, 1907. Acquitted on ground of insanity.

**227.** N. 13-11-99. Section 457. Class III. An Epileptic Insane; found to be so while undergoing two years' imprisonment for Section 457. Very aggressive at first, now quieter but always stealing. Still in asylum and most troublesome from his habit of stealing everything.

**228.** D. 17-8-06. Theft. Section 380. Class III. Sentenced on 3-4-06 to two years' rigorous imprisonment and 30 stripes for theft in a building. This man seems to be a moral imbecile; he is continually thieving in the asylum; is a plausible shamefaced man, otherwise sane, but he is lazy, a liar and a most able thief, uninfluenced by reward or punishment.

**229.** A. 1-5-00. Acquitted on ground of insanity under Section 454. Had been of weak intellect for some years, said to be a wandering lunatic, entering bungalows and stealing articles without regard to their value or utility to himself.

A demented chronic maniac, very destructive. Still in asylum.

**230.** R. 1-8-00. Section 457. Caught in act of stealing a cow and its calf in company with another man who ran away; Rama stayed. When admitted, found to be demented. Unaltered up to present time, 1907.

**231.** H. S. 18-11-97. No particulars of crime.

Unable to plead. Section 457. A chronic maniac, subject to fits of violence. Still in asylum in that condition.

**232.** N. B. 10-9-98. No particulars of crime.

Sentenced to one year's rigorous imprisonment under Section 457. A melancholic, later becoming partially demented. Still in asylum, 1907.

**233.** M. 25-8-00. Sections 454 and 457. Class III. Found to be insane while undergoing six months' imprisonment under Sections 454 and 457. No details of crime.

Admitted in a condition of subacute mania; he rapidly became demented and died 7-5-06.

**234.** G. S. 24-9-00. Section 457. Class III. Found insane while undergoing a year's imprisonment under Section 457. No details.

When admitted, was recovering from acute mania. Left asylum sane on 17-4-01.

**235.** S. 10-1-02. Class III. Section 454. Became insane while undergoing six months' imprisonment under Section 454. No details.



**LURKING HOUSE TRESPASS.** A case of melancholia, gradually became exalted, with delusions of being in charge of the asylum, etc. Still in asylum, 1907. Frequently most aggressive.

## CHAPTER XLV.

### ARSON AND INCENDIARISM IN INSANES.

#### *Pyromania.*

Certain insanes show a tendency to conceal fire and to burn anything they possibly can; also it has been found that many persons convicted of this crime (arson) have become insane during confinement. Among European writers, other than English, a form of insanity, characterised purely by an instinctive irresistible impulse "to burn," has been described under the name of pyromania—a true "impulsive" insanity, but it seems to be now generally recognised that, though such a disease may possibly exist, it is of most extreme rarity, and that the desire to burn, to set fire to things among insane people is almost invariably a symptom of other mental disorders.

1st.—It is seen among imbeciles—it is well known that idiots and imbeciles are often mischievous and destructive, and cruel, especially as they reach the age of puberty, and one way in which they show the tendency is in incendiarism; often it is merely the desire to see a blaze, or a childish motive to destroy, while just as often there is no motive discernible whatever.

2nd.—Many cases, especially on the continent, have been described in which young girls for some obscure reason fired articles when in a state of nervous excitement with "headache, general malaise" and hallucinations of hearing, occurring at the time of first menstruation, and numerous other cases when this symptom appeared in connection with nervous disorder coincident with sexual derangement have been recorded. Such are certainly unknown among the natives of India.

3rd.—It is a crime of moral imbeciles (instinctive criminals). Just as some of such individuals will commit any crime, others especially when actuated by a trivial irritation or without such even will, in order to cause damage, set fire to property, while others again show a peculiar liking for this form of mischief without any obvious motive.

4th.—Most common of all, and practically the one almost always seen among Indian insane, is for the habit to be remarked in melancholics of a mild type, in whom sometimes the emotional condition is so little marked as to afford an explanation of the old opinion of the existence of a special form of insanity, *i. e.*, true pyromania, with the impulse to burn as its only symptom. Such patients are quiet, retiring, self-engrossed, clean and decent, usually keeping to themselves, and spending much of their time sitting in a corner in meditation. Though they rarely speak of their own initiative, they can, like most melancholics, answer questions fairly sensibly. They are, however, always trying to conceal fire about them and with it to burn either their own habitations, or those of others, frequently quite regardless of the danger to themselves in so doing, and when questioned as to the reason, they give some evasive reply or answer foolishly. One man, Buta, a patient here in December 1904, caught in the act of firing his own bedding, and asked his motive, replied in his habitual weak, half whining voice "it came with my chapaties" and would say no more. Nothing cures such individuals, and their safeguarding, entailing as it does constant unrelaxed supervision, is a matter of the greatest difficulty.

It is superfluous to add that treatment is futile. They have, however, a strong tendency to recover, which, of course, never happens with the examples afforded by imbeciles and instinctive criminals.

5th.—Other rarer instances of this tendency are afforded by some insanes who burn in obedience to an hallucination, fancying they hear a voice ordering them to do so, or as a result of some delusion—while just as an acute maniac will do any impulsive act of mischief or destruction, many of them, without any clear intention to do harm, will fire their own houses, bedding, etc., such is a very frequent complaint made in the police reports sent in with a maniac on his admission, and such tendency is said to be peculiarly frequent in sufferers from *Mania á potu*. Some dements unable to reason or judge of their actions, will, if not watched, and if left with fire, accidentally burn articles just as little children would, and among Europeans suffering from General Paralysis of the Insane, the symptom in obedience to some exalted ideas of power or authority is also rarely met with. Broadly speaking, persons in India charged with this crime (not a common one) and judged insane, are either imbeciles or melancholics, and

usually the latter. No woman has yet come under my notice charged with this act, and no plea for irresponsibility could be conscientiously advocated by a medical man, unless the accused showed other symptoms of insanity, or those of general imbecility or unless a clear history of congenital moral imbecility could be brought forward.

Only very occasionally has such a tendency been recorded in Epileptics.

#### EXAMPLES.

**236.** S. 13-8-99. Section 436. While suffering from mania set fire to 23 huts in a village.

Acquitted on ground of Insanity. Recovered. Discharged on security 28-5-02.

**237.** A. M. 17-6-92. Subject to attacks of recurrent melancholia, in one of which he committed arson; no details. Discharged on security 16-11-04.

**238.** K., a Hindu, age 30, admitted 30-8-04. Crime during insanity following alcoholism.

Sentenced to one year's rigorous imprisonment for setting fire to crops. Evidence being adduced that, shortly before this he had been considered insane and was in the habit of causing mischief, etc., he was on appeal acquitted on the ground of insanity and sent to the asylum.

No clear history of his insanity is available.

All insanity or epilepsy in family denied; he owned to being occasionally intemperate with spirits, but denied the use of drugs. On arrival he appeared sane and has remained so up to the present time, 13-5-07.

**239.** F. H., 26, English. Admitted 16-1-04.

Charged with setting fire to a building on 21-8-03, half an hour after which he was admitted to hospital for "acute mania," headache, delirious "illusions" of sight, saw a man in the corner of the room whom he wished to murder. Heard voices. Had suffered from the "sun" in Burma 1897, and at Ambala in 1901. His attack this time followed a day's exposure and began with violent headache for which he took "2 pegs of brandy." Has now no memory of the occurrence. It appeared that he fired a heap of papers in the office where he was cashier and assaulted a native with his pocket knife who happened to come in. He owned to being of very intemperate habits. On admission he was perfectly sane and remained so until transfer to Colaba on 14-5-04.

**240.** B. R. 24-8-01. Section 436, I. P. C. Arson. This man who had previously acted in an insane manner, several times beaten other people and set his own house on fire in several places, was acquitted on ground of insanity. Subject to attacks of Recurrent Mania. Discharged to stand trial 2-2-02.

## CHAPTER XLVI.

## SEXUAL CRIMES IN THE INSANE.

Certain idiots and imbeciles when they reach puberty, and in whom, as in a great number of those profoundly idiotic, sexual desires have not remained undeveloped—often give way to reckless and open masturbation, or commit sexual assaults on unprotected children and women.

Epileptics very occasionally are said to do the same, though no crime of this nature has ever come under my notice.

Old people, especially men in a condition of mild senile mania, just as they lose self-control in other ways, so for this reason, plus the exaltation and eroticism that attends this disease, may indecently expose themselves, some are detected in attempting unnatural offences, while others make indecent assaults on very young children, etc., just as in a milder condition of commencing senility, which is often attended with a re-awakening of the sexual passion, an old man in advanced years will propose to and contract marriage with a young girl.

General paralytics occasionally make assaults of this nature in the early stages of the disease; and the same is conceivably possible as a result of a delusion in any form of insanity.

Mania in either the simple acute, or chronic variety, especially in the acute, is very frequently attended with lewd language and gestures, open and excessive masturbation, exposure and (given the opportunity) attempts at sexual assaults. The melancholic, on the other hand, shew usually such an amount of retardation and lack of energy as to make an occurrence of this nature very unusual, though many will remain naked but not necessarily or usually with any such motive.

In both these latter the insanity of the patient is obvious and not likely to be called in question, and the same may be said of the crimes committed by idiots. Sexual crimes and unnatural offences do not form anything more than a very minute proportion of those connected with insanity, the latter scarcely ever. As is well known, sodomy is habitual throughout Asia, and unnatural offences very common, and form a striking example of a legal offence not regarded even as a vice by the ordinary population; it is of course present among insanes but not more commonly, indeed less so than among sane natives of the country, but this tendency should always be remembered; and the weak

and helpless patients especially at night separated from the stronger, and from those likely to force them to accede to their desires on this subject.

Though these do not, as before said, commonly form the subject of judicial enquiry, the patients being generally so obviously diseased as to be usually already under restraint. sexual malpractices and offences are, especially in India, extremely common among the insane. Masturbation is a very frequent and trying symptom, especially among idiots; chronic maniacs and demented, a very large number, especially among women, wilfully expose themselves indecently; many use gross and lewd language. The female patients are pre-eminently given to these habits, and the very large number endeavour to be habitually naked, while some of them inflict cruel injuries on the sexual organs of little children.

Quite apart from one of the effects of the loss of inhibition, characteristic of insanity, showing itself in some persons of strong passions in a desire for sexual gratification, evidenced by lewd gestures and improper advances, a condition often seen in acute mania or chronic mania, some imbeciles and in commencing G. P., there has been described under the heading of Nymphomania in the female and Satyriasis in the male, an insane state characterised by an irresistible impulse to satisfy the sexual appetite, while some others have restricted the term to this condition when it arises solely from morbid irritation of the sexual or reproductive organs, and when it appears solely to originate in cerebral influence, have styled it erotic insanity, though by this term is usually understood, however, a morbid desire for some one of the opposite sex without sensual passion. In the case when simply irresistible carnal appetite is the sole prominent symptom, this is almost always another example of an "impulse" so often seen in some varieties of insanity, and in no way constitutes a variety *per se* worthy of a distinctive name. A nymphomaniac is therefore usually a person suffering from mania or other variety of insanity with a marked "impulse" in this direction—there may be sane people in whom chiefly as a result of defective training or environment, habits of self-indulgence have grown up in this respect to a high degree: but whatever views we may take of their subordination to their instincts and desires, we cannot say that this habit alone proves they are insane. Erotic excitement is a frequent accompaniment even in virtuous, well-conducted people of simple mania, but then it is only in part a symptom of the general disease. Likewise, in persons of neurotic temperament, a condition commencing on local irritation may supervene on attacks of eroticism. One such came under my notice in a girl of 11 of a degenerate family with an acrid discharge from the vagina, the nature of which we were unable to discover in whom, when treated, the symptom ceased at once. Certainly, in these latter there is no such condition of the will as to admit any plea of irresponsibility. It is noteworthy that in true insanity eroticism is frequently found associated with religious and mystic tendencies.

In Europe where, unlike this continent, the crime of unnatural offence is looked upon as being also a shameful and unnatural vice, some writers have described various forms of sexual perversion, which though they may be urged as pleas of irresponsibility,

are in the opinion of most English authorities only examples of the result of defective training in persons of depraved habits, usually commencing as masturbation (a fairly common error of childhood), but in these people continued throughout life.

The people referred to are supposed to have an "innate" passion for their own sex, men for men and women for women; with a distaste for the natural sexual relations, even an incapacity. The evidence is chiefly derived from the confessions of such people, and the utmost that can be said in support of it is that they are frequently people of neurotic heredity, and that their physical appearance does not conform to the sex to which they belong, though this does not always follow. A very strong and obvious argument against the correctness of supposing such an irresponsibility as these writers would claim for these depraved beings, is that in this continent where sodomy is so largely practised nothing of the kind is ever suggested.

There are some other aberrations of sexual appetite, however, which commencing in morbid peculiarities and habits formed perhaps at first from accidental association in early life, verge into what are in the opinion of some undoubtedly insane desires and impulses.

In these some object not essentially connected with the sexual act is declared by those affected to be very potent or absolutely necessary for arousing sexual desires.

(Various terms—Masochiism, sadiism, and fetichism—have been given to these conditions). Though they cannot strictly be taken as evidences of insanity, such morbid desires undoubtedly exist, and form the explanations of these strange acts of people who occasionally cut off pieces of clothing, of hair, and of others who steal boots, etc., who are accused of "prodding" women, etc., etc. Sadiism is the endeavour to increase sexual excitement by brutality, while in masochiism, on the other hand, the endurance of pain holds the same place.

In Fetichisim it is the conjunction of particular articles, clothing, underclothing, boots, etc. (which seems necessary for the stimulus). In some this is a boot, a fur, velvet and article of female dress; the examples are endless. Others find it necessary(?) to accompany the sexual act with biting, violence, and these are the cases which fade imperceptibly into those rare examples which undoubtedly exist, when maniacal impulses to mutilate and murder their victims are given way to, and which are without

doubt the explanation of the series of brutal murders of this nature that occasionally take place. Such peculiarities and crimes are fortunately, as far as my own experience goes, practically unknown in this country, and few persons, did such ever occur, would be found to support the irresponsibility of those who were accused of them.

**NOTE.**—On the whole subject of the irresponsibility of sexual pervers, the words of Mercier, *Criminal Responsibility*, p. 145, are worth quoting.

"If the community sees fits to punish the acts by which such perverted desires are gratified, I see no reason why persons of this class should not be held responsible. There is no reason to suppose that the perverted desire is any more urgent than the natural desire," "the existence of large classes of lifelong celibates who unquestionably observe their vows of chastity proves that the natural desire is susceptible if not of total suppression at least of complete control, and therefore if the perverted desire is no more urgent than the natural desire, and I know of no contention that it is, it seems that the sexual pervert should be considered as fully responsible for the act in which he gratifies his desires."

#### EXAMPLES.

**241.** K. 24-6-97. Section 326. Acquitted on ground of Insanity. Accused of attempted rape on a girl of 10, inflicting severe injuries on her; was then "commonly regarded as mad." A chronic mania. Died in asylum 26-1-02.

**242.** H. 29-7-97. Section 102. Class III. Became insane in jail while undergoing a year's imprisonment under Section 102. A chronic melancholic. Died in asylum 29-11-05.

**243.** B. 29-6-01. FRONTIER ACT 32. Class III. Found to be insane in jail while undergoing three years' imprisonment for adultery under Frontier Act. A case of melancholia, still in asylum.

**244.** R. A. Sections 576 and 511. Rape. Found insane while undergoing five years' imprisonment for rape.

This man was formerly a collier—fell, injured his head, in consequence of which epilepsy set in and he was obliged to leave the mine. He enlisted, lost his fits before that and up to time he was sentenced, but the fits began in jail once more after a fight in which he again injured his head. He was certified as being semi-demented in consequence of epilepsy, with delusions of persecution. In the asylum, on arrival, he appeared the same, with fits at intervals of about a week, but these ceased in about five months and his mental condition rapidly improved. He became sane and was discharged 22-4-05 for deportation to England.

**245.** M. 23-3-01. Section 358. Class III. Assault, Became insane while undergoing three years' imprisonment under Section 358. No details. Sentenced on 3-9-99. A case of chronic mania, still in asylum.

The few remaining cases of persons accused of mischief, bad livelihood, etc., complete the list of all the criminal insanes in the Punjab, confined from 1-1-00 to the end of 1906, the whole of whom have been under treatment in this asylum.

**246.** F. R. Admitted 4-12-77. Acquitted on ground of Insanity. This man, a demented melancholic, was found after Shabkadar eating the dead bodies. Died of chronic dysentery 10-7-02.

**247.** S. S. Admitted 12-5-98. Unable to plead. A case of Toxic Insanity, arrested for having while in that condition torn down telegraph poles. Recovered and was discharged sane 9-8-00.

**248.** D. K. 25-1-99. Section 147. Class III. Rioting. Convicted of committing riot, etc. A chronic maniac who since the date of admission has been violent, incoherent and aggressive, and is still in the asylum in that condition.

**249.** Z. S. 21-12-99. Section 353. Became insane in jail while undergoing one year's rigorous imprisonment under Section 353. (Criminal force to a public servant, etc.) No details. A chronic maniac with delusions of wealth, etc. Died in asylum 6-12-06.

**250.** Z. A. 28-11-05. Section 107. Class III. Age 18. Sentenced to a year's imprisonment in default of security under Section 107.

A case of simple mania from which he seems to have repeatedly suffered previously. Discharged sane 16-9-06.

**251.** S. U. K. 9-3-06. Section 109. Was found loitering about quarter-guard of R. I. Fusiliers at Pindi; ordered to find security for good behaviour. A suspected rifle thief.

Apparently was in a condition of simple mania, of which he had one recurrence after admission. Discharged sane 8-2-07.

**252.** G. S. 9-3-06. Ordered to give security for good behaviour or suffer imprisonment for six weeks as member of a tribe of rifle thieves. Admitted in a condition of melancholia from which he gradually recovered.

**253.** H. 18-8-06. Sentenced to two years' Rigorous Imprisonment under Section 107. Said to have "assaulted his mother with an axe." An epileptic insane. Still in asylum.

**254.** S. 25-11-00. Section 109. Class III. Abetment. No details. Found insane while undergoing seven months' imprisonment under Section 109. Admitted in a condition of melancholia, but rapidly recovered. Discharged 15-5-01.

**255.** A., a Pathan, age 35. Sentenced to a year's rigorous imprisonment for failing to find security for good behaviour on 19-7-02. Section 110. No particulars known previous to admission. A chronic maniac, incoherent without power over his attention, though clean and not destructive. He is occasionally aggressive, assaulting others with no provocation, has remained in this condition to present date, May 1907, becoming more demented and is now a confirmed mud eater and in consequence dying.

**256.** A., a Pathan, age 35, admitted 7-8-03. Dementia Præcox. Sentenced to three years' rigorous imprisonment under Section 123. C. P. C., on 13-6-03; he was found to be dangerously violent and was in consequence transferred to the Lunatic Asylum.

**COPY OF CERTIFICATE.** "Incoherent talk, tearing his beard off, beating his head against the iron bars of his cell, thereby injuring himself. Vacuous grin nearly always present, sleeps very little at night; on opening cell he attempts violence to others."

There is no family history or previous history of the patient obtainable on admission, nor of the onset of his disease. Is a medium-sized, unhealthy-



looking man, with a curiously humorous expression of face, always repeating the same words. His speech is sensible, coherent; he replies to questions and understands what is said to him. Memory, good. Attention, wanders, but can be roused. He is quiet, clean, modest, and not destructive, but has some peculiar tricks, thus he is generally seen to be sitting down covering his eyes with his outspread fingers.

He occasionally becomes excited and unruly, though usually very cheerful and always silly in manner, perpetually making some comic gesture.

His behaviour and manner of replying does not render it possible to say whether he has hallucinations or delusions. It is almost certain that he has the former (hallucination). Up to 12-3-04, he remained the same silly in appearance, speech and behaviour, always smiling and self-satisfied, speaking coherently but in a demonstrative fashion. But he then changed, became quiet, miserable, spent most of the day with his head against the wall, motionless.

By the middle of next month he was quiet, but again fantastic and childish, silly and foolish, but giving no trouble was discharged on 23-5-04 on security.

On 30-12-06 he was readmitted, having become dangerous, had thrown his brother into a pond, etc.

In much the same condition, makes foolish gestures and grimaces, usually puts his fingers on his lips in place of replying, goes about half naked, assumes curious attitudes. He never asks to leave the asylum and is very self-satisfied and self-contained. Is frequently mute, at other times repeats one monotonous phrase. Of late he has become very destructive to clothing, but is otherwise unaltered. Speech has been absolutely coherent throughout.

## CHAPTER XLVII.

### RUNNING AMOK.

To "run Amock" or Amuck is a term, naturally of great notoriety, applied to a condition in which a man suddenly, without warning, arms himself with a lethal weapon, rushes out and kills (or attempts to) every person he meets indiscriminately and continues to do so until himself killed or overpowered. Soldiers take up their rifles for this purpose, natives and others arm themselves with a sword or some cutting instrument; there is no selection of victims; it is an indiscriminate slaughter of every one, in this contrasting with the acts of a Ghazi.

This condition is not an insanity in the ordinary sense of the word. Almost invariably it will be found to be the result of intoxication (among natives, from Indian Hemp, among Europeans, in whom it is relatively more rare, from Alcohol), producing a condition of blind fury. There are, however, a few cases met with not preceded by such an indulgence when a murderous "fury" seems to seize a person brooding over some indignity, some wrong or a series of real or fancied slights and ill-treatment, a condition

analogous to that popularly described as of a man who "sees red" "turns Berseker," etc. No case of a woman exhibiting this condition has ever come under my notice. Curiously enough, it is said that, when a Malay runs Amok, the act is practically a method of committing suicide, and that it is effected for that purpose, the man knowing full well that he will ultimately be shot down himself, and this being regarded as a suitable and manly method of terminating an existence that is deemed undesirable.

In the opinion of the writer in no case could a plea of insanity or irresponsibility be put forward in any of these cases; generally of course no such question arises, as what usually happens, is that it being impossible to apprehend the offender, he is killed by some one in self-defence.

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## APPENDIX.

### AN ACCOUNT OF A RACE OF IDIOTS FOUND IN THE PUNJAB, COMMONLY KNOWN AS "SHAH DAULA'S MICE."

There are in the Punjab a comparatively large number of microcephalic imbeciles or idiots of very uniform type commonly known among the people as Shah Daula's mice. Shah Daula being the patron saint of a tomb and shrine in Gujrat, under the protection of whom they are supposed to be, and their name of "mice" being usually explained by a supposed resemblance to their flattened skulls and prominent ears bear to these animals. Rightly or wrongly, a certain amount of mystery as to their origin, etc., has always been associated with them. They are usually to be met with wandering about the country, each under the charge of a faqir, and their pitiful appearance and condition is undoubtedly used as a means of exciting sympathy and hence extracting alms that might not be otherwise obtainable. It was largely believed that many of them were of artificial production,—a view I may say, certainly with regard to all I have examined, to be utterly without foundation. Common rumour is, however, very persistent on this point, and their charge is obviously a source of gain to those who now retain them, and from certain indirect evidence it is not impossible that the widespread tales of iron caps being applied to the heads of any children of this appearance in order to compress the skull and still further impede its growth may not in the past have been without some foundation. The proportion of these imbeciles in existence is certainly larger than that met with elsewhere or in Europe; they all bear a close resemblance, and they all seem to spring from the poorest members of the community, and to be chiefly restricted to certain districts of the Northern Punjab, but as they are not reported to be commonly sterile, and considering the paucity of women in some districts, and the custom of intermarriage of the people, their number is not perhaps so very surprising. Their close relation to the shrine, however, from which they take their name, requires some explanation.

There is only one of these idiots now in this Asylum (Punjab Lunatic Asylum), but another—a little child—lives in the vicinity of Shahdra, and an infant was also seen in 1900 in Lahore. In May 1902, in company with

the Officiating Inspector-General of Civil Hospitals, Punjab,\* I visited the shrine from which they take their name, and was shown all that could be collected on the short notice given them; these were fifteen in number, a tabulated statement of whom, with measurements is here appended. The idiots (who are usually imbeciles only) are remarkably uniform in appearance and characteristics with the exception of No. 3, who had more of the peculiarities of a dwarf. They are, however, one and all much below the usual stature for children or adults of their own age; the majority are children. There is, as a rule, no bodily deformity or disease, except that four had well-marked internal strabismus,—but there was the striking peculiarity that the ears almost invariably stand out at right angles to the skull, and are proportionately large.

The head-shape is, however, the distinctive feature. This is small as a whole and also in relation to the size of the body, the most marked change being in the extremely small size of the skull circumference and in the diminution of the convexity, giving the idiot a most peculiar appearance, heightened by the effect of the small wizened faces, which, however, have often a remarkably sharp, shrewd expression, never in the least fatuous; the two sides of the head are always equal, there is never any scar or mark of injury or disease, and the hair grows thickly. The contour of the face is always regular, the teeth normal, and the palate only in a few cases slightly heightened, and never cleft. The vertebral column showed no peculiarity. Sight, touch, taste, and smell give no signs of impairment, but six out of the fifteen of them were deaf and dumb, and this, according to native reports, is the condition of the majority. Of those that can speak the intelligence is of a low order, and all indeed show varying degrees of mental impairment. Those that talk cannot carry on any lengthy conversation; their language is scanty, their replies slow in being elicited and vague, generally consisting in repetition and monosyllables; this, however, is largely due to defective training, for the one in this asylum shows considerable power of language; they are, however, one and all incapable of understanding anything but the simplest remarks; they show wonderfully little initiative, are content to sit idly and quietly on one side doing nothing, though peering about occasionally when aroused. They offer no resistance to any order, and seem actuated by few desires or impulses; they will allow any one to take away their belongings, and have little or no idea of self-protection. I never heard one speak except in reply to a question, nor saw any of the females show that love for jewellery so characteristic of women of their class.

On the other hand, though careless of their personal appearance, and sometimes being of dirty habits—more, it seemed to me, from deficient opportunities of being otherwise and from want of training—they are not immodest or indecent, and are not wantonly filthy. They can all feed themselves, and do not display, like other idiots, revolting tendencies or appetites; it is rare to find them give way to passion, and only one of the number was shown to me as in any way remarkable for irritability. They never show delusions or hallucinations.

As a rule, they have memory, though its scope is much restricted, and they display a certain amount of affection to children and to those who treat them well, and they are capable of being taught simple employments. In none of them is there ever any form of epilepsy. It was remarkable that though they resisted nothing else, several made most determined opposition to any measurement or examination of the head, and two absolutely refused to allow it to be done,—a peculiarity commented on by some of the onlookers as proof of the justice of the prevalent opinion that their skulls had been subjected to ill-treatment to still further increase the deformity, and that the idiots remembered this and were afraid of its repetition.

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\* Colonel T. Hazlett Browne, M.D., I.M.S., C.I.E., Inspector-General of Civil Hospitals, Bengal.

In no case, however, was the skull deformed otherwise than in its diminution as a whole, nor was there in any that peculiar distortion posteriorly described as occurring in the North American Indians, who habitually subjected the skulls of their children to pressure.

None of the imbeciles exhibited any paralysis or deformity. The hand grasped one's own with some strength, and did not lie limp and flaccid as is so often seen, and it was obvious that none were post hemiplegic (infantile). In only one were the extremities blue and livid (the dwarf, No. 3, before referred to), and she suffered from general malnutrition, but though all were in appearance in fair general health, it is noteworthy that no one had ever seen or heard of one at an advanced age, and it seems clear that the majority die young.

I was anxious to obtain some history of each and some account of their families of origin, but the guardians of the shrine could or would tell me nothing beyond a vague statement to the effect that several had had brothers and sisters similarly affected, and that only one of the entire number had a mother who was a "Chuha."\* The idiots themselves could tell me nothing. The guardians, however, were all agreed that the condition had existed from birth, and this was obviously correct.

In one case I had an opportunity of examining the male relations; these were healthy, and I could obtain no history of disease in the mother, of difficult labour, or of hereditary influence, and the condition of the child was clearly congenital.

It must be remembered that those I saw formed only a small proportion of the number in all probability in existence in the Province, for though no figures are given in the recent census, there were stated to be 43 in 1885, and, as I am informed, 100 in 1891.

I have never had the opportunity of examining one of these skulls *post mortem*.

In regard to the connection of these micro-cephalic imbeciles with the place from which they take their name, there is in the town of Gujrat a shrine and tomb known as that of Shah Daula, a Mahomedan "pir," or saint, who died in 1676. The shrine is much venerated in the district and has an immense reputation throughout the Punjab, and though now poor and much fallen from its former high state, still it and its "maliks" and attendants continue to be held in great respect. It has been the custom for some two centuries apparently whenever one of these idiots (commonly called "Chuhus") are born, for the mother, directly the child was a few years old, to present it and leave it in charge of the malik of the shrine to which henceforth it was supposed to appertain, and from whence it was supported. The parents being always of the poorer classes, it is conceivable that the care of a helpless imbecile such as these generally are, was a heavy tax on them, and that this may have been formerly the reason for the custom which by its antiquity—as always happens in this country—has become one impossible now to overcome. It is, however, to be remembered that only children deformed in this particular way were received. Formerly, there is not the slightest doubt, the infants were kept at the shrine, which was practically an asylum for them where they were tended and cared for until death; but this is not so now for, whether from failing means, lax discipline or corrupt morals, it is certain and admitted by all that from originally allowing some of them to only occasionally go out with the faqirs attached to the tomb into the district together alone, the custom has spread, until at the present day it is the invariable rule for them all to be actually leased out on a monthly payment to these men, who carry them into all parts of the Punjab, begging, and, it is asserted, neglect and ill-treat them, so that now it is only possible to see at the shrine itself the few who happen to be accidentally there at the conclusion of a round. The payment made by the faqir for each child varies, I am informed, from Re. 1-8 to Rs. 2 a month.

\* The brain was later destroyed by a careless attendant.

The history obtainable of the origin of the shrine is, though scanty, of an interesting character. Shah Daula, in whose honour it was founded and whose tomb it contains, was a Mahomedan "Pir," born in the time of Akbar, who lived in that capacity at Gujrat from 1612 to 1676 after having previously lived at Sialkot for 22 years.

He had early gained a great reputation for his liberality and talents, and was undoubtedly a man of great ability and influence. Many water-courses, tanks and bridges still exist of which the construction is attributed to him. The record of his good deeds being, as was common in those times, soon adorned by tales of his capacity for working miracles: he had also a peculiar fondness for taming wild animals, deer, etc., many of which he kept at the shrine, of which some he would later on turn loose after marking them, a habit which still further tended to increase and extend his reputation. There is no doubt that this propensity of his caused his name to be constantly associated with animals and possibly was the origin of beliefs which certainly existed that (1) he had a miraculous power over them, and (2) that he could cause a child to be transformed at birth into an animal (*ergo* a Chuha—a rat—a microcephalic idiot) if the parents offended him or failed in their promises of gifts they had vowed when asking a favour.

In any case his tomb was largely resorted to after his death—and apparently is even now—by childless women who were in the habit of vowing a large gift or the dedication of the future child to the service of the shrine on condition of their prayers being heard; and it was currently believed—and is, I understand, still now—that any woman who neglected to fulfil this vow would be punished by giving birth, not to a healthy child, but one of these so-called "Chuhas," if not on the first occasion, then certainly on the second.

It has been suggested that the mental influence of this was occasionally responsible for their production, and, with even more probability, it was hinted that the guardians of the shrine would not hesitate to make use of the male microcephalic resident there to ensure that some of the childless women who spent the night at the shrine in supplication should reproduce one and so maintain the reputation of the tomb for its power in this particular.

On the other hand, the custom Shah Daula certainly had in his lifetime (he having been undoubtedly a generous, careless man) of receiving any stray animal or wandering child or helpless creature, and of giving it food and shelter for an indefinite period, may have been the origin of the dedication of helpless children to his shrine, and particularly of those peculiarly deformed creatures who in the opinion of the common people so closely resembled animals, and hence had a double claim upon the generosity of himself and his descendants. The fact is in any case well known that every microcephalic imbecile of this character above the age of infancy is without exception dedicated to this tomb and from birth is known as a Shah Daula's Chuha, though, as before stated, almost all are to be found each in company of a faqir wandering about the country. There is a current belief that it is unwise to refuse alms to one of these men when leading a Chuha, as otherwise the offender's next child may be born in a similar condition, and the fact—well attested—of their paying for the privilege of procuring one is a proof that their attendance is profitable. So much so and so well known is this, that there was, and indeed, still is, a belief throughout the Punjab that such idiots are sometimes manufactured artificially by compressing a child's skull with an iron cap worn for a long period. I am not aware of there being any actual proof of such a practice, and certainly an examination of their heads negatives any such supposition, for the skulls are diminished as a whole, and never misshapen or distorted as would in such cases happen, but there is equally little doubt that these men to whom they are entrusted ill-treat and neglect them, and for this reason, if not for the obvious objection to allowing the females to so wander about unprotected, it is evident that the law which

lays down in the Punjab that such idiots when found should be transferred to an asylum, should be rigidly enforced, and not neglected as at present. There is not the same objection to their retention in the shrine itself where, being well known, and its inmates always open to inspection, their condition is comparatively safe, though, on the other hand, the revenues of the tomb have from various causes now fallen so much that the plea of the headmen (themselves direct descendants of the disciple and reputed son of Shah Daula) that they are unable to maintain them is probably true. Some action should certainly be taken to alleviate the condition of these poor creatures whose deformity renders them quite unable to protect themselves, and who are so singularly devoid of all the more revolting habits common to many idiots, for no destructive and immoral acts are ever attributed to them, and the imbeciles are so well known that such a tendency would be soon made public. All the evidence obtainable indeed goes to show that they are a class of harmless imbeciles whose peculiar cranial conformation is concomitant with a general mental enfeeblement, frequently *plus* an inability to speak or hear, with a great absence of will power,—the same having existed from birth unattended with motor paralysis or epilepsy,—and without history or evidence of injury or disease to which their condition could be attributed.

*Addendum.* Since writing the above, another case has come under my observation in the asylum. It is that of a male, age apparently about 30, height 4 feet 7 inches, circumference of head at widest part 16 inches; he was of the usual type, could speak and hear, walk and feed himself, and was without deformity or any paralysis, but of a very low grade of intelligence, his language most rudimentary; he died a few days after admission of double pneumonia. At the *post-mortem* the skull was absolutely normal in appearance, but contracted in every direction; the brain appeared normal to the naked eye, but it has been reserved for microscopical examination.

### DEMENTIA PRÆCOX IN INDIA.

A certain number of cases (and that not at all a small one) of insanity among young adults in this country, including both Natives of India and Europeans born here, present the characters of that disease described elsewhere under the name of Dementia Præcox. It may be summarised as a mental disease of adolescence which among Indian insanes at any rate is never recovered from, of prolonged duration commencing, rarely, with a simple change of disposition, but oftener with a mild attack of excitement or with (perhaps most usually), one of depression, always showing hallucinations from the outset and later a peculiar tendency to grimacing, silly tricks of behaviour, a characteristic speech and manner, a peculiar combination of apathy, emotional dulness and defect of volition, the whole passing inevitably into a characteristic weakness of intellect in which very early defect of voluntary control over the sphincters and general feebleness of judgment and reasoning power contrasts markedly with perfect retention of memory to a very late period. Certain unusual physical symptoms accompanying the disease throughout.

Whatever the objection and there have been very many urged in Europe against the use of this term of Dementia Præcox under which the similar cases met there are described, the question of its suitability as a name is of little moment compared to that of the existence of a distinct disease to justify such being classed separately; unquestionably, however, a definite clinical entity of this nature exists, the actual appellation most suitable for which is of absolutely no practical importance, and the writer's object in the present article is to describe the symptoms met with in a comparatively large number of patients mentally afflicted, seen in this country, who in his opinion are of this nature; the symptoms in all being

fairly uniform, extremely characteristic, the patients in whom they appear being invariably incurable, so that a definite and certain prognosis can be given from the outset when they are once recognised (a conclusion it may be here pointed out very difficult to arrive at in most cases of insanity), the whole forming, at any rate, a definite and distinct clinical entity from a consideration, of which we may say, at all events, that in young adults here a form of mental disease is met with presenting these symptoms which never ends in recovery, but always terminates in a characteristic Dementia : that this is unlikely to be simply a peculiarity due to the period of life at which ordinary insanity has attacked these patients because we also often see in others of a similar age, ordinary mania and melancholia, but without these peculiarities characteristic of Dementia Præcox ; in fact, all the usual forms of insanity quite indistinguishable from the same seen at any other age and which then terminate in the usual manner.

We may therefore urge that any and every form of insanity in early adult life is not Dementia Præcox, for the ordinary clinical varieties are also then met with. That this disease in other words, is not simply mania of adolescence and that it certainly does not comprise all adolescent insanity, but is a distinct and separate variety of mental affection. For while it must be owned that many of these cases do certainly give one an impression that perhaps it may be, that in some young adults from impaired congenital cerebral condition, when an attack of ordinary insanity occurs, the brain becomes so easily injured that recovery is impossible, and that for this reason they remain permanently weak-minded ; yet against this and bearing largely in favour of this being a totally distinct malady is the indubitable fact that this weak-mindedness is always preceded by characteristic symptoms ; that practically only those cases of insanity at that age with them do so terminate, and more especially that the Dementia resulting is in itself characteristic and absolutely unlike that following any other mental disease.

Some objectors also urge that Dementia Præcox is an unsuitable name because cases have been described as occurring in other than young adults, but the writer is now speaking of insanies in India where, as far as his own experience goes, the commencement of this malady is practically confined to the ages of between 15 and 25 and is never seen in older people.

In this country, as everyone is aware, it is extremely difficult to obtain any previous history of a patient, and especially is this the case with regard to insanies. When such is available, however, the person afflicted with this disease is usually described as having been a very quiet, retiring, shy and self-absorbed youth, frequently as having been very studious ; indeed, the disease seems here most common among those well educated (though I have seen well-marked examples among illiterate Pathans). All are certainly, however, of a docile, amenable, quiet disposition, and I have yet to see an instance of it in a bully or ferocious character.

A history of masturbation is sometimes (not often) given, but this is nearly always really an early symptom and not an antecedent ; even if true, however such a large proportion of young natives do masturbate that this in itself would not be an extraordinary fact, but what is noteworthy and always worth enquiring into if the symptom is mentioned is whether the act was concealed ; its not having been so is a very clear proof of its having been really an early symptom.

The large majority of the patients present some physical stigma, often several, and the most frequent are those common to so many insanies in this country : (a) an inequality in the two sides of the face and of the halves of the vertex of the skull, the largest side of the face corresponding to the smallest side of the vertex ; (b) defects in the ears ; (c) hyperextension of the phalanges ; and (d) flat feet. When a family history is obtainable, the patients will almost always be found to be of a neurotic stock. Some cases in whom there was a history of severe head injury preceding the onset have come under my notice ; the accident has, however, always

happened one or two years at least before the commencement of the disease, while curiously the scars shewn as proof of the injury have always been of the frontal region of the skull.

The malady usually shows itself in one of two ways : either (1) you are told that a patient has gradually changed in disposition ; though he may have been formerly studious, you will be informed that he had left off work or ceased to persevere to attain the object of his study (I say he, because the symptoms of this disease are of such a nature that the sufferers, if females, can conveniently be retained at home until very late, being rarely dangerous and still more rarely criminal, and of course no female without such characteristics would ever be brought to an institution, so that, it results that very few, but males come under notice) ; he becomes untidy, hopelessly idle, singularly wanting in initiative or interest in anything. He is always wandering aimlessly about ; frequently—remarkably frequently—you are told that a young man in good employment quite suddenly goes away from it and is not found for some time, and by this I mean that he will walk out of his workshop or office without reason or obvious motive, without notice or preparation, perhaps in the middle of the day, without money, without a word to anybody, in the clothes he stands up in, without baggage (a very striking fact in a European), and undertake a long journey by rail, if he happens to have money upon him, and if not, on foot. In one case, a young man at Karachi walked out of his post in his office in this way and was next heard of in Amballa.

Presently, the utter change in disposition and habits, the absolute cessation of all evidence of initiative and energy becomes so evident that the patient is brought for treatment as an insane. (2) The other type of commencement is either an outbreak of silly petulance, restlessness and destructive violence, or a fairly rapid change of the patient into a condition of mild melancholia, when he is depressed, anxious, silent, until questioned, devoid of all initiative, slow, furtive in manner, sometimes in addition to being sleepless, refusing food and showing a tendency to dirty habits—obviously insane—giving either no comprehensible reason for his depression or some peculiarly silly, fantastic explanation or delusion, a peculiarity that strikes one forcibly throughout the disease. However it commences, a little cross-examination will reveal the essential feature of this affection which is never absent, and that is, the presence of hallucinations from the onset. The patient will tell you that he hears voices, that spirits talk to him, that birds speak, snakes come up and whisper to him that water rises in his room, that ghosts torment him, that leaves tell him various things ; the content and description is usually silly and impossible, always changing and never forms a fixed or systematized delusion ; the hallucinations are pre-eminently auditory, though visual are to a less extent met with, and sometimes those of taste and smell, although tactual hallucinations are very rare.

Now, an ordinary, simple melancholic, such as these persons often appear at first sight to be, never has hallucinations, nor are these seen mild in cases of mania, while they are still more unusual in a person who has simply become weak-minded, vicious and lazy ; and such a combination, when there is no history of indulgence in Indian hemp or alcohol to account for the peculiarity stamps the case as almost certainly one of commencing Dementia Præcox, especially when it is noticed that unlike a young person with ordinary mania or melancholia, there are no marked emotional outbursts ; that also he is not "divertible," as it is said that the speech is different and that also he will usually eat, filthily it is often true, but still that he usually does and that he also sleeps more than does a case of ordinary adolescent insanity.

However, he may commence, such a patient never recovers ; and whatever form the initial state may have been, he soon lapses into



either a chronic condition, typical of its kind, or else sinks rapidly and progressively into one of absolute dementia equally characteristic.

The chronic form is the most frequent termination and is also that one, from the habits of the people in which we usually see such patients in India. It is a condition that may last for many years (several of nine years duration having come under my notice), though its even tenor may be occasionally broken by outbursts of boisterousness and noisy restlessness or even impulsive destructiveness, usually of short duration; and it is curious that if you question such a patient after one of these, though unlike an ordinary case of mania, etc., he can answer sensibly and does usually. If asked for the reason of his conduct he can and will give no explanation, but makes some stupid, frivolous reply; he adduces no explanatory delusion and has in fact no "insight" into his own condition.

The fully developed symptoms are fairly distinctive, the patient is furiously apathetic, shows very little initiative or desire for anything. As every one connected with an asylum is too well aware, the majority of patients in it, if they are capable of framing a demand, invariably exercise this capacity in requesting you daily and all day to let them get out; you will notice that a case of *Dementia Præcox* never does so. From the first all employment, all occupation is neglected, and the patient rapidly becomes incapable of following his former trade or livelihood, and as the disease becomes well marked, it will be seen that not only is this so, but that there is the greatest difficulty in making such a one do anything; there is no active resistance to one's efforts but simply a listless inability. If a European, he will be on his bed all day, or if a native, will sit loling in the shade of a verandah. Such a patient never assists in the asylum, for instance, and so marked is this that if you see a man employed on any of the numerous trades and requirements of the institution, you may be quite sure he is not suffering from *Dementia Præcox*. Nor do such patients, like most others, at any moment come up and bother you with endless questions and requests and complaints. If they do any thing, it is to avoid you, though this often is too much trouble. They will, as already said, sit about all day and literally do nothing, and, what is more striking, they seem to have no desire to try to do anything even to amuse themselves. Though many smoke to excess, they have lost all interest in anything and everything, and nothing seems capable of arousing them to have any, and when they do move or act, these have all a peculiarly senseless, aimless character that is rather typical.

With this there is great emotional dulness; the patient never "gets excited" in the true sense of the word; he never has an outburst of emotional excitement, yet what seems a contradiction to this is frequent chuckling laughter "at nothing" as we say, which is very common as are (less so) intervals of weeping and crying, equally without reason, the laughter being without mirth and the weeping utterly without signs of misery.

This apathy and emotional dulness is very evident at the visits of relations. They do not, like other patients, hurry to meet them, shed tears of emotion, beg to be removed, and, after enquiring about home and people, part with them weeping. Quite the contrary—they go to the gate slowly and indifferently, stolidly, take all that is given which they frequently eat silently in front of them, looking at their visitors steadily without a trace of emotion all the time, never asking after their home, the welfare of the fields and cattle or of their women folk, and finally, go back to their rooms without remonstrance or resistance.

Yet they obviously comprehend everything said and done before them, remember all their past life, recognize everyone and fully understand where they are and who they are among.

At a very early period all these patients become wet and dirty; they nightly soil their bed, passing fæces and urine into it and in their clothes, while from the first they have become utterly regardless of any cleanliness or of personal appearance, and what is very significant, they never adorn themselves with rubbish like an ordinary chronic maniac; and though they never show any shame or consciousness of their filthy appearance, yet at the very time when they will act in this way and show the marked apathy and emotional dullness alluded to, yet, unlike an ordinary dement, they will be found to have—at any time absolutely perfect memory to be able, when they please, speak coherently and readily, to walk about composedly and to be able to exercise volition. Indeed, this combination may give an unpractised observer the impression that such a patient is only filthy from laziness and viciousness. They do not, however, like some "maniacs" wantonly foul themselves and their meals with excreta, and their acts in this respect seem to be only another instance of their general apathy and want of initiative. Still, a tendency to dirty habits and indecency is, however, very prominent in all these cases. They are nearly all filthy in regard to their excreta; many of them are constantly making obscene gestures and postures, many are always naked and others masturbate openly, and the trouble they involve for this reason in nursing and supervision is very great.

Then too they have a great and striking tendency to silly habits or mannerisms; everything about these patients' acts is "silly"; they are always grimacing, putting themselves in some absurd posture, though with all this is done in a way that gives a superficial impression of cunning, and as though affected in impudence and purposely—all peculiarities which combined with their characteristic speech are absolutely typical of this disease and found in no other.

One man here at the sight of any one screws the eyelids forcibly together and "boos," as though blowing through paper instead of speaking—he also is usually naked; another when accosted invariably distorts his face to one side as though paralyzed (he is not), and replies with "all right" in a curious twanging tone, though quite capable of speaking sensibly; another stands on one leg resting the sole of the other on that, though at the same time putting his tongue out; and another boy stands stark naked, and at the sight of an official bends his head forward until it about touches his toes; another, and he a European, if left for a moment, likes to strip naked and lie silently and at full length on his back directly in the middle of the garden path; others will emit one monotonous cry or word for hours together, a few will repeat several words in the same manner, and the varieties of this "stereotypism," as it is called elsewhere are endless. A very large number will sing to themselves or on request, and it is worth remarking that their song is not an incoherent jumble but a repetition of something they have learnt long gone by, for with these people all previous knowledge is well retained until very late.

The speech is absolutely characteristic (at least in the chronic variety); it is always fantastic and silly like their acts, but unlike that of a case of mania in whom the rapid flow of ideas and diversion of the attention by every passing sense impression—results in a sentence being often not completed and so appearing incoherent—that of a sufferer with *Dementia Præcox*, though often absurd in its content, is for each sentence a coherent whole, each sentence is finished, though each may be and usually is ridiculous; a reply will be given though often an absurd one. What are you doing now A? R.—I am waiting for Lord G. to bring his yacht to my bedroom, sir, etc. What is still more striking than this is that extremely frequently the speech is given in an affected falsetto or mimicking voice. A European will imitate a cockney accent, a Pathan will use an ascending shrill tone, and another native will

answer with the face drawn up to make some absurd grimace, in a voice that irresistibly reminds one of Punch at a Punch and Judy show; the examples that could be cited are endless. It is obvious from this that sustained conversation is impossible with them. The first impression given to one is that the man is certainly playing the fool and this is heightened by his acts and gestures. It is easily conceivable that it would be very difficult for a non-medical man to resist such an impression on seeing a young adult for the first time, who on being asked by him as to his health, replies, with a mimicking grimace and in a cockney drawl "Oh we are 'awl' right here my good man," and when he sees such a patient when left alone sitting on the edge of the bed doing nothing with a sullen attitude, a feeble grin and senseless chuckle, wet and dirty, it is, one can imagine, very difficult for such a person to resist the idea that an individual so acting is only playing the fool or malingering, specially when the patient can be proved to be perfectly oriented to have good memory and to look as all such do look, not ill at all, but in fairly good health and well nourished (many, however, it must be allowed, are very pale and anæmic). The facies at rest is placid except for the eyes which are usually bright and active; it is expressionless, though at other times this is replaced by a silly leer or fantastic grimace. The clothing is always untidy and dirty and often extremely filthy; the disregard for personal appearance being absolute. As before said, comprehension is unaffected and orientation unimpaired, while memory is, until the last, absolutely perfect; and the latter forms a very striking contrast to the patients' manner, appearance, behaviour and mental capacities. Not only past but present memory for events, time and place is also unimpaired.

The will is weak, that is to say, these patients can be led about and directed by almost anybody, though they are always giving way to some impish trick or mannerism. A certain number show a dull obstinacy at varying intervals and the so-called negativism of Katatonia must be separately referred to; but cases of ordinary Dementia Præcox do not, however, in this country show an opposition to suggestion and direction. They are not, as a rule, actively destructive, though they may be for short periods boisterous, restless with a tendency to break articles near at hand, a tendency perhaps best described as impulsive and purposeless. Of these actions they have perfect memory, though they can or will give no explanation except perhaps a ridiculous one afterwards. A few show delusions always of a senseless, silly character. The patients described elsewhere in whom delusions are so prominent, as practically to constitute a distinct variety of the disease are in Indian asylums very rarely met with. The hallucinations remain about constantly from the outset; they are usually very distinct, and it is difficult to resolve them into illusions. They may be annoying in character, but are never fearsome and never lead to violence or retaliation.

The movements are slow and apathetic, though some of the tricks and mannerisms are quick; these too may be of an irritating character.

Prolonged observation of all will assure you that they are perfectly conscious, have full knowledge of where they are and who they are surrounded by, and also of time, that is to say, that their apprehension is perfect orientation and "consciousness" unclouded; nor have we here noticed any defect even in the cases of more acute onset. In all this they contrast strongly with the ordinary dement, or with cases of acute mania, chronic melancholia or any variety of insanity from drugs or exhaustion. They do, however, exhibit a great weakness of judgment and their speech and conduct also lead one to imagine, at any rate, that there is a great poverty of ideas and their loss of control is shown in their tendency to the aimless, impulsive actions, which characterise so many, while they also have the usual self-satisfaction with their own conduct and behaviour seen in all cases of mental disease, just as like all these it

is utterly impossible to reason with them or to arouse them in any way from their condition of apathy, stolidity and dulness. They have no "insight," as it is said, into their own condition unlike many cases of melancholics, etc., and on account of their very dulness and the total abolition of all interest in anything and everything, attention appears to be very defective; or at least even if control over it is possible, there is no effort at effecting it.

Physically, the frequent presence of stigmata of degeneration has been already alluded to; there is no marked evidence of constitutional disturbance, though in the very young examples these are often here—weak and ill-nourished and frequently anæmic; with ordinary care in any asylum these, however, grow to maturity and normal stature. There are, however, one or two striking organic peculiarities. Nearly all these patients if they do not actually have an excess of saliva formation, at any rate give one the impression that they do, for the majority are perpetually spitting. The quantity of urine is also apparently in excess, though from their habits it is not possible to accurately estimate its amount. The patients are certainly not constipated, but show a tendency to great looseness of the bowels. The pulse is usually quick and of bad quality and remains so throughout, while here is always a marked affection of the respiration. Usually this is very infrequent, 10 to 8 a minute being sometimes seen, but in other cases it is rapid, but this is extremely shallow, almost imperceptible; in all it is liable to great alteration during examination when a patient will frequently cease to breathe for 30 seconds or longer, and what is more remarkable, when he does recommence, there is no marked acceleration, such as there would be after such an interval in a normal person.

The reflexes are, if anything, rather more easily obtainable than in health, but not to any very marked extent. In a few, a very few, the symptoms show a modified remission for some time; they become quiet, apathetic, obedient and not demonstrative, and in this condition are occasionally removed by friends. But it will be seen that even at their best they are utterly changed from what they were before admission, and they are always incapable of following their original employment, and the disease almost invariably recommences and then their filthy habits, the difficulty of caring for them and the trouble they give on that account almost invariably necessitate their being sooner or later returned to the asylum where they stay until death. This may be delayed for many years; in one case here it did not occur until advanced middle life, though in the large majority some intercurrent disease, frequently phthisis, carries them off long before that period. No treatment here has been ever found of any service, and the pathology of their disease is still a matter for discovery.

A very excellent example of the disease is presented by a young European (born in this country) who has been in this asylum since 1905.

It appears that he is a tailor of most respectable parentage, who had received an excellent education and had been sent to England when 20, to learn his father's trade, but while there, had wasted his time and given way to vice and riotous living. He was brought back to India and was "set up in business" on his own account, but soon failed by reason of his negligence and intemperance, and on this happening, enlisted only to be discharged as useless after some five months' service. He then appears to have wandered about the country, as do so many of these cases, and finally drifted to the local workhouse from whence he was sent to this asylum for treatment and has remained here ever since. It is noteworthy that he was noticed in the workhouse to masturbate freely, but there is little doubt that his disease had commenced in England and that the vice was only another example of his impaired intellect and loss of control, as were his indulgences, intemperance, loose conduct and his inability to earn his own living anywhere, for on arrival here his disease was already advanced and in a chronic condition. Though perfectly able to speak sen-

sibly and with accurate memory, he would give absolutely no details of his previous life, talked and replied in a hesitating fashion, was extremely reticent, pretending ignorance on all matters, personal and private, so that his previous history was only obtained later from his relations. He seemed morose and a little dejected, lay like a log in bed all day, was untidy and uncleanly, acted as though of defective intelligence and was utterly lacking in interest in his position or welfare, made no remonstrance as to his detention, and indeed seemed not to trouble in the slightest about the matter, was devoid of shame and self-consciousness, absolutely indifferent to his surroundings and careless of the future.

He was a big ungainly youth with bright twinkling eyes, but a fat immovable face (except when this was contorted into a grimace), thick everted lips and rather large outstanding ears, always, when off his bed, standing in a slouching nerveless attitude with the head bent towards the ground.

He appeared to have no desires or interest in life except perhaps what might appear so in his craving for tobacco. Although there was no history obtainable of any acute "emotional" onset to his disease since coming here, he has had occasional outbursts in which he behaves either like an ill-tempered, pettish child or is foolishly destructive and noisy and inclined, though he is a great coward, to bully the native servants, and with these exceptions he has never varied. He has none of the obvious self-satisfaction and obtrusiveness of the chronic maniac nor the depression of the melancholic. He is not "divertible" nor obstinate, can be led about and controlled by anyone; and though he has occasionally thrown away his food, etc., usually eats greedily and voraciously. He is full of tricks and mannerisms, will stand for long periods in one attitude, will take off his clothes and stand naked at the main gate, will lie on his back, also naked, in the middle of the main garden path, and is in fact always posturing and grimacing, mimicking a Frenchman or imitating somebody—the only occasions on which, it may be added, that he speaks of his own accord. Yet it can be proved that he has perfect memory, both past and present; retains all his past knowledge and education. He can speak sensibly and reply accurately and to the point, but in general his language is silly, fantastic; though each sentence is coherent in itself, its content is absurd and ridiculous often as though purposely so, and it is impossible to carry on a conversation with him. From the first he has been very filthy, he passes his excreta in his bed or clothes, and when asked the reason why, mimics a French accent and usually replies "I am sure I don't know, sir; shocking, isn't it?" and is deaf to all remonstrance or appeals to his better sense.

His attention is different and difficult to arouse. Though emotionally dull, he is obviously pleased when asked to sing a comic song, of which he has a large repertoire, and one of which he gives in a horrible voice with huge delight, figuring and posturing to illustrate it, often stark naked without the least self-consciousness. He allows his clothing to become soiled and torn, and nothing will induce him to keep himself clean or tidy, or to occupy or amuse himself in any way except in posturing or grimacing, laughing in a silly, senseless manner or talking in some silly, ridiculously affected way, which often gives one the impression that he is playing the fool and acting intentionally of set purpose. But with all this, when visited by his mother, he displays not the slightest emotion (and though he used at first to write and that fairly sensibly, though always for the purpose of making some ridiculous request), never asks after the welfare of any of his family, never demands to be taken away, and parts from her stolidly, taking everything she brings, devouring greedily all the eatable portion, and behaving then as on all occasions more like a dirty, untrained, silly, pettish child, than the well-educated man he really is. At first he had fleeting delusions of wealth, etc., and of friendship with many titled persons, with hallucinations of hearing, but

with his increasing weak-mindedness these are now difficult to elicit. For the last year he has been absolutely stationary, filthy, incapable of reasoning or judging, apathetic, indifferent to everything, the picture of dirtiness and untidiness, yet capable of quick, active, impulsive movements, active in the search for food or tobacco, with absolutely perfect memory, and a speech that is unlike any other variety of insanity, but that of the instances of the disease under discussion.

As is well known, this disease is divided by Kræpelin and others into three forms: (1) hebephrenia which practically includes the cases, of which a description has just been attempted; (2) a paranoidal form in which delusions are the most prominent feature, masking all the other symptoms; and (3) katatonia, a description of which latter, as met with here where it is a fairly common disease, must be reserved for a future paper.

The paranoidal form is in India, at least as far as my experience here goes, extremely rarely seen. We have here at present, however, two cases; one is that of a powerful young frontier man, always naked, perpetually smiling, grinning and chuckling, with silly laughter and self-satisfied, whom on account of his habit of annoying the others, we find it necessary to keep always shut up by himself unlike any ordinary insane native, and despite his definite delusion of grandeur, he never makes any objection to this and never begs to be allowed out or to go away, never desires to send letters, and is perfectly content to sit or lie, doing nothing the whole day—at most asking for a cigarette; it is surprising what a desire there is (practically the only one) for this amusement among these cases. This man also shows typically the usual apathy, emotional dullness, indifference to everything and everybody, the inability to employ himself or to carry on any sustained conversation, and the senseless gestures, tricks and mannerisms and grimaces so characteristic of this disease. But also on arrival he declared that he was a near relation of the Prophet and cited hallucinations of voices to support his contention and claimed all sorts of wonderful senseless powers and capacities in consequence, and also modified his conduct to a certain extent on this belief. As usual, however, as time advanced (he has been here since 1905), these delusions faded and are only now recalled on questioning, and probably with advancing dementia will practically cease altogether.

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Calcutta, July 1908.

# Thacker, Spink & Co.'s Publications.

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